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Relationships among counselor moral development, multicultural counseling competency, and attitudes towards people who have disabilities

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RELATIONSHIPS AMONG COUNSELOR MORAL DEVELOPMENT,
MULTICULTURAL COUNSELING COMPETENCY, AND
ATTITUDES TOWARDS PEOPLE WHO HAVE DISABILITIES

A Dissertation

Presented to

The Faculty of the School of Education

The College of William and Mary in Virginia

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Christine Sacco-Bene


June 2004

RELATIONSHIPS AMONG COUNSELOR MORAL DEVELOPMENT,
MULTICULTURAL COUNSELING COMPETENCY, AND
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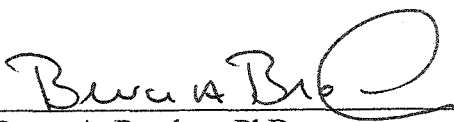
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DEDICATION

This document is dedicated to those who are the most precious people in my life. To my husband, Will Bene, I love you so much and cannot even put into words how much I appreciate you supporting me throughout this process with an unwavering support and unconditional love. You are so important to me and I thank God for bringing you into my life. To my little princess, Elyssa Avery Bene, you have shown me what is truly the most important in life. Through your innocence and young wisdom, I have learned when to stop working and enjoy life. Thank you for being my daughter and my teacher. To my mother, Michele Sacco, I hope that I can become half the woman you are. I never cease to be amazed with your many talents and gifts. I love you and appreciate all that you have done for me throughout my life. Finally, I dedicate this document to the late John A. Sacco. I miss you Daddy.

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RELATIONSHIPS AMONG COUNSELOR MORAL DEVELOPMENT,
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ATTITUDES TOWARDS PEOPLE WHO HAVE DISABILITIES

ABSTRACT

Multicultural competency literature and the field of multicultural counseling are broadening their scopes to include factors associated with other areas of human diversity. However, the largest minority group, people who have disabilities, is often overlooked or ignored within counselor education programs (other than rehabilitation). The consequence of this dilemma is that counselors are entering the field with little or no knowledge about disability related issues or how to work most effectively with individuals who have disabilities. When working with clients who have disabilities, counselors who process their experiences at the higher levels of cognitive development have been shown to function more effectively in variety of counseling tasks, including problem-solving abilities, empathy, ability to recognize individual differences, and valuing client diversity. To date, however, there has been limited research examining the relationships of cognitive development, multicultural counseling competencies, and attitudes towards people with disabilities.

The purpose of this study was to bridge the gap of the limited research in this area. As such, the study was designed to investigate the relationships among counselors' moral reasoning, their perceived multicultural counseling competencies, and their perceived attitudes toward people with disabilities. The theoretical framework for this investigation was the moral development domain of cognitive developmental theory. For data collection five self-report research instruments were used: an investigator designed demographic form, the short version of the Defining Issues Test (Rest, 1990), the Multicultural Counseling Knowledge and Awareness

Scale (Ponterotto et al., 2002), the Attitudes Towards Disabled Persons Scale (Form O; Yuker, 1986), and the Marlowe-Crowne Social Desirability Scale (Form C; Crowne & Marlowe, 1960; Reynolds, 1982).

It was expected that positive relationships would exist among the variables. It was concluded, however, that positive relationships existed between moral reasoning and perceived multicultural counseling awareness competencies, and perceived multicultural counseling awareness competencies and attitudes towards people with disabilities. Perceived multicultural counseling knowledge competencies were not found to be statistically significant with moral judgment levels or with attitudes toward people with disabilities. Nor, was there a relationship found between counselors' level of moral judgment and their attitudes toward people with disabilities.

Further research is needed to better understand how these variables relate to one another for the purpose of continuing to make improvements in counselor education and counselor professional development. Ongoing improvements in the field are important so counselors can continue to, or begin to, respond competently and effectively to the unique set of challenges presented by our society's growing diversity of clients.

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CHAPTER ONE

The Problem

Introduction

The concept of disability is as old as the history of humanity itself. Throughout this history, disability has been described and influenced by a variety of factors (Hunt & Matthews, 2001) each offering diverse ways of assisting people with disabilities. Despite the many improvements that have been made over the past several decades in regards to medicine, technology, education, legislation, and the services provided to individuals who experience disabilities, the history of people with disabilities has often been difficult and oppressive (Gilson & DePoy, 2002; Olkin, 1999; Sue & Sue, 2003; Wurst & Wolford, 1994). Perceptions of disability in society have traditionally dictated how individuals with disabilities were treated. Because there are many different types of disabilities that people may experience and disabilities transcend race, ethnic, gender, sexual orientation, and class lines, the issues related to those who experience disabilities are wide ranging (Olkin, 2002).

Problem Statement

For the reason that disabilities are ubiquitous, “mental health professionals need to understand the nature of disabilities and treat individuals with dignity” (Sue & Sue, 2003, p. 422). The goal of counselor education programs, and not just rehabilitation or disability studies programs, should be to prepare and assist students in becoming sensitive, skilled, and knowledgeable change agents for their clients, including clients who experience disabilities (Lofaro, 1982; Strohmer, Biggs, Haase, & Purcell, 1983). Generally, curriculum, discussion, and analysis of people with disabilities are often looked at with a deficit-treatment perspective or are completely ignored by many counselor education and other related programs (Gilson & DePoy, 2002; Milsom, 2002; Olkin, 2002). Bluestone, Stokes, and Kuba (1996) found that in graduate

programs in psychology disability issues received the least coverage when compared to other areas of client diversity including, ethnicity, gender, aging, socioeconomic status, and religion. As a result, counselors and others in related studies too often enter the field with limited knowledge or skills regarding disability-related concerns (Marshak & Seligman, 1993). Consequently, this deficiency negatively impacts counselors' ability to work effectively with clients with disabilities.

Studies have documented that professionals' attitudes affect their effectiveness and behavior when working with individuals who experience disabilities in such areas as teaching (Miller & Cordova, 2002), rehabilitation counseling (Grayson & Marini, 1996; Kemp & Mallinckrodt, 1996; Strohmer et al., 1983), the medical field (Seligman & Darling, 1997), and the field of business (Chan, Lee, Yuen, & Chan, 2002). For counselors who do not have positive attitudes toward individuals with disabilities, the effects are potentially detrimental to the clients' well-being and self-worth.

Exposure to people who experience disabilities has been shown to improve students' and counselors' knowledge, attitudes, and skills (Chan et al., 2002; Lofaro, 1982; Miller & Cordova, 2002; Strohmer, et al., 1983) – the building blocks to multicultural competencies (Arredondo & Arciniega, 2001). According to the analysis of Chan et al. (2002), those who had exposure to or, more importantly, contact with people who have disabilities gained more information about the disability itself and appeared to have more positive attitudes toward people who experience disabilities. To treat clients with true dignity, it is also essential for counselors to be aware of their own biases when working with any population, including individuals with disabilities.

As all counseling is multicultural in nature (Arredondo et al., 2001; Das, 1995), recognizing one's own biases is a crucial element of multicultural counseling competency. Other dimensions of multicultural counseling competencies include understanding clients' value

systems and worldviews, as well as having knowledge of the various forms of oppression experienced by these individuals and how that oppression may influence the counseling relationship. There is, unfortunately, a possible down side to this position of defining all counseling as multicultural counseling (Das, 1995). Das suggested that by defining all counseling as multicultural there is the potential to preserve the status quo thereby continuing to ignore or ineffectively serve diverse populations, including persons with disabilities.

Given the understandable importance of training multiculturally competent counselors, particularly as our society continues to grow more diverse, the concerns listed in this section bring to light the following questions: Are counselor education programs providing sound theory-to-practice frameworks to meet this training responsibility? Are programs training counselors to work effectively with clients who have disabilities? Or, by defining all counseling as multicultural, is the development of the counselor's skills, knowledge, and attitudes for serving other diverse minority populations (e.g., those with disabilities), as suggested by Das, being compromised?

Diversity

Though viewed historically as a deficit, disability has recently gained consideration as an "element of human diversity" (Gilson & DePoy, 2002, p. 153). In many training programs, diversity training curricula, however, still focus predominantly on race, ethnicity, and racial identity and downplay other individual differences, such as disability (Olkin, 1999). As a result, there is inconsistency in practice and the literature regarding the use of the word *diversity* and its relationship to multiculturalism. In their landmark article operationalizing multicultural counseling competencies, Arredondo et al. (1996) delineated two important concepts, diversity and multiculturalism. Their definition of multiculturalism refers to an individual's race, ethnicity, and culture. Whereas "[d]iversity refers to other individual people differences, including age,

gender, sexual orientation, religion, physical ability or disability, and other characteristics by which someone may prefer to self-define” (p. 44).

Working from these definitions, the challenge, then, is for counselors to work effectively and from many vantage points with clients who experience disability. From the perspective of disability issues alone, individuals who have disabilities are truly bicultural. They are positioned in both the “disability minority world” and within the “‘able-ist’ majority world” (Olkin, 1999, p. 90). Therefore, effective counselors must understand their clients’ perspectives and worldviews while also being aware of external, societal factors that affect their clients. Often people with disabilities enter into counseling with issues that mirror those experienced by their able bodied peers; but, due to the fact that they have disabilities, are faced with negative bias and countertransference by the counselor. The potential of these negative effects merit attention given those in the counseling profession tend to mirror the same common attitudes as those in society in general, and society’s overall perceptions of disability are often negative (Leigh, Powers, Vash, & Nettles, 2004). Counselors must be able to view their clients holistically, taking into consideration other human factors (e.g., race, ethnicity, culture, religion, age, sexual orientation, gender) including, but not limited to, disability.

Multicultural Competencies

As this country becomes even more multiracial, multiethnic and overall pluralistic, there is a growing need to meet many more and different mental health requirements of a wider range of clients (Constantine & Ladany, 2001; Holcomb-McCoy & Meyers, 1999). The change in the cultural composition of society has necessitated a review of traditional counseling theories, which were based predominantly on a monocultural, individualistic perspective (Hill, 2003; Sue, Arredondo, & McDavis, 1992; Sue, Ivey, & Pedersen, 1996). Resulting from the shift from a culture-bound perspective to one of multiculturalism, there has been a proliferation of models

developed over the past decade that attend to counselor competencies regarding diverse populations (e.g., Arredondo, Toporek, Brown, et al., 1996; Sadowsky, Taffe, Gutkin, & Wise, 1994; Sue, Arredondo, & McDavis, 1992). Each of these models addresses the knowledge, attitudes, and skills necessary for counselors to work effectively within a multicultural frame.

Though there are some differences in the specific content, the knowledge, attitudes, and skills necessary to competently counsel individuals who experience disabilities, this group also has a lot in common with other minority groups who experience discrimination, prejudice, stereotypes, and bias. Persons with disabilities, for example, have been disadvantaged in many areas of life including: economically, socially, politically, educationally, and personally (Olkin, 1999). For counselors to truly possess multicultural competencies when working with clients from diverse groups that have experienced such disadvantages, they are required to have higher order, more specific, and sophisticated counseling skills as well as an awareness of their own values and biases and of their clients' worldviews (Fuentes et al., 2001).

Attitudes towards People who have Disabilities

As was mentioned previously, individuals in the human services professions, including counseling, tend to present the same common attitudes towards people who experience disabilities as those in the general population (Elston & Snow, 1986; Sue & Sue, 2003), and these attitudes often determine how people in society operate and respond to persons with disabilities (Barrett & Pullo, 1993). Research has indicated that counseling professionals continue to maintain stereotyped beliefs and biases towards people with disabilities (Goodyear, 1983), and the outcome of these negative attitudes often have impeded counseling effectiveness (Fish & Smith, 1983; Gilson & DePoy, 2002; Marshak & Seligman, 1993). Because many of the negative attitudes come from incomplete and incorrect information in an individual's belief

system (Chan et al., 2002), there is a need to increase the counselor's awareness and positively affect the counselor's attitudes toward people who have disabilities. According to Das (1995), the cognitive distance between mental health service providers and ... minority consumers can be bridged through didactic instruction, but the social and emotional distance can be reduced only through an intensive program of reeducation of the counselors, one aimed at changing attitudes. (p. 47)

Currently, the literature describes two primary ways of increasing awareness and promoting positive attitudes toward individuals who experience disabilities. The first is through education that includes conscious raising elements, such as, educational films, guest speakers, and simulation exercises (Grayson & Marini, 1996; Lofaro, 1982). The second method of promoting positive attitudes is through direct exposure to individuals who experience disabilities (Miller & Cordova, 2002). Miller and Cordova suggested, however, that the combination of education and social contacts provide the most effective way to change attitudes toward persons who have disabilities. Although there are numerous research projects in the literature highlighting the importance of disability education and direct contact with individuals who experience disabilities for changing attitudes toward persons with disabilities, a majority of this related work is found in professions other than counseling. In addition, neither of the means of affecting change, education or exposure, have taken into consideration the counselors' psychological developmental processes nor have they been based on theoretical foundations.

Theoretical Rationale

Cognitive Development

From a developmental process perspective, human behavior is not defined by a single cause; rather, human behavior results from multiple causes (Paisley & Peace, 1995). Cognitive developmental theory posits that the people's actions are related to their cognitive complexities.

That is, cognitive developmental theories are constructivist stage theories which are "... universal structures of knowing that evolve based on the person's encounters with challenging environments, and his or her subsequent accommodations to new ways of knowing" (McAuliffe & Eriksen, 1999, p. 269). Depending on the type, amount, quality, or timing of the experiences, the innate human potential can be promoted or restrained (Mosher & Sprinthall, 1970; Paisley & Peace, 1995).

Counselors who process their experiences at the higher levels of cognitive development are apt to perform more altruistically and humanely than those at lower stages, or less complex stages of development (Sprinthall, Peace, & Kennington, 2000). Furthermore, according to Sprinthall et al. (2000), counselors at higher levels of cognitive development tend to achieve greater efficiency and effectiveness in a multitude of counseling areas, including problem-solving abilities, empathy, ability to recognize individual differences, valuing cultural diversity, and being aware and knowledgeable of self. As this country becomes ever more diverse, it is imperative that counselors meet the unique set of challenges presented by the growing society. As indicated by Fuertes et al. (2001), counselors who possess multicultural competencies are also likely to possess higher order counseling knowledge and skills. Counselors who operate at higher stages of cognitive development are more likely to employ these same counseling skills and the ability to complete complex tasks (Sprinthall, Reiman, & Theis-Sprinthall, 1993).

Cognitive development as a theoretical base has been used to facilitate cognitive growth and psychological development in a variety of research endeavors (Foster & McAdams, 1998; Rest et al, 1986; Sprinthall, 1994). In fact, various domains of the cognitive developmental theory have been used to map how people go through qualitatively different perspectives in their knowledge development (Marchesani & Adams, 1992). The theories of cognitive development

include the domains of moral reasoning (Kohlberg, 1976), ego development (Loevinger, 1976), and conceptual complexity (Harvey, Hunt, & Schroder, 1961), among others.

Moral development. The theory of moral development (Kohlberg, 1976) has been used in a variety of applications to promote the development of moral reasoning and cognitive complexity (Richardson, Foster, & McAdams, 1998). According to Hayes (1994), “counseling is fundamentally a social activity, and Kohlberg’s work does no less than call for conceptualizing counseling as a developmental process of social interaction” (p. 261). Because counseling is important, not only to client development, but also counselor development, moral developmental theory frames the therapeutic relationship. In fact, this relationship itself is established in the moral developmental theory because the listening that occurs in the confines of counseling requires empathy and role-taking, both of which are elements necessary for moral growth for both the client and the counselor (Hayes, 1994; Kohlberg & Wasserman, 1980).

As counselors develop more specific and enhanced moral perspectives, they become better able to empathize and make accurate analyses of situations, and therefore, are likely to construct appropriate behavioral responses (Thoma, 1994). These skills are essential when counseling diverse populations, especially clients who experience disabilities, because counselors who are otherwise unsure about their ability to assist diverse populations may in fact demonstrate sympathetic or patronizing interactions, which ultimately hinder the helping relationship (Lofaro, 1982).

Empathy, on the other hand, is one of the higher level counseling skills that occurs when a person takes the perspective of another person (Gibbs, 2003). That is, the person is able to put himself or herself in the position of the other person. When working with clients who have disabilities, “the counselor must be able to examine his or her view of disability and identify and question prejudicial assumptions” (Sue & Sue, 2003, p. 430). The self and one’s perspective

taking is transformed and the relationships with others are redefined at each stage in the individual's development (Gielen, 1991). Counselors at higher stages of moral development are likely to have more accurate empathetic communication and less prejudice than those at lower stages of development (Gibbs, 2003; Peace, 1995; Rest & Narvaez, 1994).

In addition to empathy as a means for understanding another person's worldview, developing an enhanced level of awareness of self and of others' perspectives can also come through the act of social role taking. "Role-taking leads simultaneously to more differentiated conceptions of self and of others" (Gielen, 1991, p. 23). Because higher levels of counselor moral development are based on the ability to take on more complex degrees of role-taking (Sprinthall, 1994), counselors at higher stages of moral development would be expected to have more sophisticated awareness of their clients' worldviews. Culturally competent counselors, too, are expected to be more aware of their clients' worldviews as well as their own attitudes and beliefs that may interfere with the counseling relationship.

Therefore, to become more professionally responsive, a counselor is required to go through developmental changes, or shifts that lead to a more advanced qualitative differentiation (Lewis et al., 1998). Enhancing the moral development of counselors seems to be beneficial as higher stage functioning of moral reasoning is better than functioning at lower stages within the counseling milieu (Rest, 1994). To meet the needs of diverse clientele, according to Sprinthall et al. (2000), it is critical for counselor education programs and services to develop counselors who have higher levels of thinking, problem solving, and ethical behavior.

Significance of the Study

Understanding the history of bias, prejudice, and discrimination regarding disability is important to appreciating how people with disabilities have been and continue to be perceived by society overall, including those in the helping professions. Despite this awareness, disability as

an issue of human diversity continues to be “ghettoized” in rehabilitation psychology and ignored, for the most part, in other human services programs (Olkin & Pledger, 2003; p. 300). As a result, professionals are entering the field with little or no knowledge about disability related issues and are unaware of their own biases, prejudices, or attitudes towards people who have disabilities.

Vash (2001) contended that attitudes dictate our behavior; and what individuals think and feel regarding an issue ultimately effects how they react to it. The negative attitudes held in society consequently work to perpetuate the ongoing discriminatory practices toward individuals with disabilities. Unfortunately, changing these societal attitudes has been and will continue to be a huge undertaking. Attitudes, after all, are complex and multidimensional constructs (Antonak & Livneh, 1988). Though attitudes are not necessarily sufficient to cause behaviors (Triandis, 1971, as cited in Lee & Rodda, 1994), they are considered to be comprised of three primary components: affective, cognitive, and behavioral intention (Antonak & Livneh, 1988).

Of the areas within the counseling process that negative attitudes can have an affect, case conceptualization and treatment planning are the most disconcerting (Carney & Fling, 1991, as cited in Barrett & Pullo, 1993; Kaplan, 1982; Marshak & Seligman, 1993). This is a concern because “... negative attitudes are believed to result in and reinforce discriminatory, biased, and stereotypical responses toward people with disabilities” (Hunt & Hunt, 2000, p. 269). Because many counselors lack the necessary information regarding disability, many, even highly skilled counselors, are in need of attitudinal change. Despite knowing that negative attitudes can perpetuate discrimination, prejudice, and bias towards people who have disabilities and that counselors are seemingly not being prepared in their programs of study to work with individuals with disabilities, there is only scant research on therapists’ attitudes towards people who have

disabilities, and, this information is primarily based on rehabilitation counselors (Kemp & Mallinckrodt, 1996).

Working with people with disabilities seems to be a challenge to many counselors as a result of the counselors' own worldviews and attitudes regarding people who have disabilities. This comes to light in the observations made by Marshak and Seligman (1993) in which they observed counselors as being ill-equipped and overwhelmed when a client revealed his or her disability. In addition, they pointed out that counselors would make critical errors in their case conceptualization and clinical judgment, which hindered the effectiveness of the counseling process. For a counselor to be culturally competent, he or she must not only aware of other worldviews, but must also be able to "identify their common emotional reactions about individuals and groups different from themselves and observe their own reactions in encounters" (Arredondo, et al., 1996, p. 62). The counselors' understanding of the disability experience and their resulting attitudes towards persons with disabilities are often distorted. Because they try to put themselves into the place of their clients and try to envision how they would contend with similar circumstances, the counselors' thinking is restricted. As a result, the counselors' understanding of the client is often based on the assumption that the client's life must be a tragedy (Marshak & Seligman, 1993). Therefore,

[i]n order to be culturally competent, mental health professionals must be able to free the cultural conditioning of their personal and professional training, to understand and accept the legitimacy of alternative worldviews, and to begin the process of developing culturally appropriate intervention strategies in working with a diverse clientele. (Sue & Sue, 1999, p. ix)

Constructivism and development are the motivating factors behind culturally sensitive counselors (McAuliffe & Eriksen, 1999). According to McAuliffe and Eriksen (1999), these

factors, at higher levels of cognitive development, facilitate a counselor's ability to take on a worldview that "... honors diversity, values equality among individuals, recognizes the influence of social context on life, and emphasizes the conditions that enhance mental and emotional growth ..." (p. 268). Counselors at higher stages of cognitive development demonstrate these abilities and also have greater levels of complexity of thinking, problem-solving, self awareness and knowledge, positive attitudes and role-taking (Sprinthall et al., 2000). Higher developmental stages, then, seem to coincide with what is suggested as necessary to be a culturally competent counselor.

To date, most of the research regarding attitudes toward persons with disabilities has considered changing attitudes or delineating where attitudinal differences have existed between professions. The research has not, however, delved a great deal into counseling fields outside of the rehabilitation focus, nor has the research considered the relationship between counselors' attitudes toward people who have disabilities and counselors' multicultural counseling competencies. Finally, the research regarding attitudes toward people with disabilities has tended to incorporate pre and post-testing within some sort of intervention, testing only the changes in counselors' attitudes toward persons with disabilities. However, such research has left out an important element – the psychological development of helping professionals.

Purpose of the Study

The purpose of this study was to investigate the relationships between counselors' moral reasoning, their perceived multicultural counseling competencies, and their perceived attitudes toward people with disabilities. The theoretical framework for this investigation was the moral development domain of cognitive developmental theory. For data collection five self-report research instruments were used: an investigator designed demographic form, the abbreviated version of the Defining Issues Test (DIT; Rest, 1990), the Multicultural Counseling Knowledge

and Awareness Scale (MCKAS; Ponterotto et al., 2002), the Attitudes Towards Disabled Persons Scale (ATDP-O; Yuker, 1986), and the Marlowe-Crowne Social Desirability Scale – form C (M-C SDS – form C; Crowne & Marlowe, 1960; Reynolds, 1982). The research focused on the degree and overall intensity of the relationships between the variables. Accordingly, the following research questions and hypotheses were explored.

Research Questions and Hypotheses

Research Questions

1. What is the degree and direction of the relationship between counselors' moral developmental levels as measured by the DIT and their perceived multicultural counseling competencies as measured by the MCKAS?
2. What is the degree and direction of the relationship between counselors' moral developmental levels as measured by the DIT and their attitudes towards people with disabilities as measured by the ATDP- O?
3. What is the degree and direction of the relationship between counselors' attitudes towards people with disabilities as measured by the ATDP-O and their perceived multicultural counseling competencies as assessed by the MCKAS?

Directional Hypotheses

1. Using a multiple regression analysis, counselors' scores on the DIT will account for more variance in the prediction of scores on the MCKAS Knowledge Scale than any of the remaining predictor variables entered.
2. Using a multiple regression analysis, counselors' scores on the DIT will account for more variance in the prediction of scores on the MCKAS Awareness Scale than any of the remaining predictor variables entered.

3. Using a multiple regression analysis, counselors' scores on the DIT will account for more variance in the prediction of scores on the ATDP-O than any of the remaining predictor variables entered.
4. Using a multiple regression analysis, counselors' scores on the Knowledge scale of the MCKAS will account for more variance in the prediction of scores on the ATDP-O than any of the remaining predictor variables entered.
5. Using a multiple regression analysis, counselors' scores on the Awareness scale of the MCKAS will account for more variance in the prediction of scores on the ATDP-O than any of the remaining predictor variables entered.

Operational Definitions

Disability

The definition of disability is divided into three elements:

“An individual must satisfy at least one of these parts in order to be considered an individual with a disability ... An individual is considered to have a ‘disability’ if that individual either (1) has a physical or mental impairment which substantially limits one or more of that person’s major life activities, (2) has a record of such an impairment, or, (3) is regarded by the covered entity as having such an impairment.” (American with Disabilities Act Handbook, 1991, p. I-25)

Moral Development

“Moral development involves thoughts, feelings, and behaviors regarding standards of right and wrong” (Santrock, 2002, p. 419), which include both interpersonal and intrapersonal dimensions (Walker & Pitts, 1998).

Multicultural Counseling

Although there are a variety of conceptualizations of multicultural counseling, this study will define the concept as that which “refers to preparation and practices that integrate multicultural and culture-specific awareness, knowledge, and skills into counseling interactions” (Arredondo, et al., 1996, p. 43).

Diversity

Though in most of the professional literature, the term *diversity* has been used interchangeably with multiculturalism, diversity for the purposes of this study “... refers to other individual people differences including age, gender, sexual orientation, religion, physical ability or disability, and other characteristics by which someone may prefer to self-define” (Arredondo et al., 1996, p. 44).

Attitudes

The definition for attitudes, for the purposes of this investigation, comes from Antonak and Livneh (1988):

... attitudes have the following elements: (a) attitudes are learned through experience and interaction with other people, social objects, and environmental events ...; (b) attitudes are complex, multi-component, structures; (c) attitudes are relatively stable (even rigid) as evidenced by their resistance to change; (d) attitudes have a specific social object as a referent (e.g. people, situations, events, ideas); (e) attitudes vary in their quantity and quality, possessing differing degrees of motivating force ... and intensity ...; and (f) attitudes are manifested behaviorally via predisposition to act in a certain way when the individual encounters the attitude referent. (pp. 9-10)

Conclusion

Given the call to counselors and counselor education programs regarding the need for multiculturally competent counselors, it is particularly important to consider this request as this country continues to grow and become a more diverse society. This chapter highlighted the concern that counselors are entering the field with limited information particularly about issues related to disability or about clients who have disabilities. In addition, this chapter brought attention to the theoretical rationale for considering counselors' moral developmental level as a predictor of their attitudes towards people with disabilities and their overall perceived multicultural counseling competencies. In the subsequent chapters, there will be an in depth review of current literature, discussion of the methods used in this study, and analyses of the study's results. The concluding chapter will discuss of contributions of the study to the field, recommendations for future research, and an explanation of the study's limitations.

CHAPTER TWO

Review of the Literature

Introduction

In the previous chapter, moral developmental theory, multicultural competency considerations, and attitudes toward people who have disabilities were considered as determinants that influence counselors' capacity to respond to the unique set of challenges presented by the growing diversification of our society. "The changing contemporary social reality of which counseling professionals are part demands a shift in many of the paradigms that have traditionally guided their work and professional identity" (D'Andrea & Daniels, 1995, p. 17). It was also noted, however, that many counseling programs, outside the field of rehabilitation counseling, do not provide adequate training to counselors in regards to working with clients who have disabilities (Bluestone, Stokes, & Kuba, 1996; Gilson & DePoy, 2002; Milsom, 2002; Olkin, 2002).

These issues are covered in more detail in this review of the literature. The first section examines attitudes and how attitudes toward people who have disabilities impact the counseling relationship. Current popular views of how training programs expose students/professionals to disability related issues are discussed. The second section considers how diversity issues and multiculturalism are taught in counseling programs and which issues are the focal points within these trainings. Finally, this review will take a closer look at moral development, a domain of cognitive developmental theory, and its correlates to multicultural counseling competencies and working with clients who have disabilities.

Attitudes

The investigation of attitudes toward people who have disabilities has been a concern of researchers ever since the early work of social psychologists such as Strong (1931) who reported

on disability groups (Antonak, 1982). Attitudes are considered to be the sum of one's feelings and cognitions as reflected in behavioral response (Bodur, Brinberg, & Coupey, 2000; Livenh, 1988; Patterson, McKenzie, & Jenkins, 1995). Unfortunately, general societal attitudes toward people who have disabilities are still reflected in negative terms. This is evident in the discrimination, bias, prejudice, or benign neglect people who have disabilities often face in work, transportation, housing, education, and in professional services. "The fundamental negative bias is important because it steers perception, thought, and feeling along negative bias to such a degree that positives are hidden. It is a powerful source of prejudice that ill serves those who are already disadvantaged" (Wright, 1988, p. 3). Because counseling professionals share the same attitudes as the general public (Elston & Snow, 1986; Hunt & Hunt, 2000; Sue & Sue, 2003; Yunker & Block, 1986, Yunker, 1994) and counselor attitudes impact their effectiveness and behavior in working with clients (Strohmer, Biggs, Haase, & Purcell, 1983), it is imperative to consider how counselor attitudes effect the counseling relationship and the overall well-being and welfare of clients who have disabilities.

Barriers to Services

To date, the empirical literature continues to show that those in mental health professions have a pervasive tendency to align with the societal notions that are largely stigmatizing toward people who have disabilities (Leigh, Powers, Vash, & Nettles, 2004; Olkin & Howson, 1994). As a result, barriers to effective mental health services exist. Researchers in one study assessing barriers to the provision of mental health services for people who have disabilities, for example, determined that this population as a whole is overwhelmingly underserved and those clients who had several physical disabilities experienced the most barriers to services (Pelltier, Rogers, & Dellario, 1985).

In another more recent investigation, Leigh, Powers, Vash, and Nettles (2004) found that barriers in mental health services still persist, almost 20 years later. The researchers surveyed two groups of APA practitioner members. The first member group had disabilities themselves. The second group surveyed was composed of members in the APA Rehabilitation Psychology division. Though there were limitations to this study, such as not having a representative sample of general practitioners in the mental health services field or attenuating for social desirability, the results of the survey were still alarming. Results indicated that there were still a number of barriers that persist in the mental health services including: lack of accessibility due to transportation and office space inaccessibility; lack of knowledge regarding disability related concerns and issues; limited information and training for providers in disability issues and services; and a lack of sensitivity on the part of the practitioner.

While these results are disturbing, such results are found on a regular basis in disability research. For instance, a study surveying adolescents and young adults who have cerebral palsy and their families with regard to service delivery they had experienced, Darrah, Magil-Evans, and Adkins (2002) obtained similar findings which supported many of the outcomes found in the Leigh et al. (2004) study. In their study, Darrah et al. (2002) performed semi-structured interviews with forty-nine individuals with cerebral palsy and their families. They determined four common themes regarding service delivery: caring and supportive people; fighting and fatigue; communication/ information; and disability awareness from these interviews with family members. Though the researchers found that caring and supportive people influenced the family members' experiences, these families overwhelmingly experienced frustration and disappointment in rehabilitation services. Much of this dissatisfaction, according to the researchers, stemmed from service providers' lack of knowledge about working with clients who have disabilities (and their families) and the providers' negative attitudes. As with any qualitative

investigation, this study too had limitations inherent to this method of investigation. Primarily, the report conveyed the participants' experiences and can not truly be applied to the larger population of individuals who have disabilities or their families. Even with the methodological limitation, the results provided those in the field with important first hand accounts, and gave voice to the participants, which helped to clarify their experiences.

Factors Influencing Counselor Attitudes towards People with Disabilities

Negative attitudes by mental health professionals clearly influence the effectiveness of the services provided and may perpetuate bias, prejudice, and discrimination towards people who have disabilities. Because people's interactions are influenced by their perceptions, knowing the variables that affect these perceptions is necessary to understand the patterns of interactions that occur between people who have disabilities and those who do not (Yuker, 1988a; 1988b; 1994). There are a number of variables that have been considered over the years that influence counseling and other mental health professionals' attitudes (e.g., gender, age, education, type of disability). Though these other variables warrant consideration, the literature has consistently shown that perceptions of the type and severity of the disability and education are considered the most important variables in determining counselors' attitudes.

Hierarchical patterns of preference have been shown to exist toward different groups of people who have disabilities (Tringo, 1970, cited in Goodyear, 1983). In fact, studies have continued to illustrate that clients with emotional and "social" disabilities are attributed the most negative attitudes (Goodyear, 1983; Wasow & Wikler, 1983). In one investigation of the perceptions of people toward others who have disabilities, Yuker (1988b) examined 53 published studies and determined 1331 data points and compiled 24 disabilities from these studies. Though the studies examined in this analysis used varying measures of to assess respondents' attitudes toward people who have disabilities, there was some commonality of hierarchy for disability

labeling. Yuker determined a rank order system of the 24 disabilities from *least acceptable* or *most severe* to *most acceptable* or *least severe*. From the results of this analysis, Yuker reported “labels do make a difference” (p. 10); and disabilities that were considered more visible to the respondents were ranked in the lower two quadrants. Disabilities such as arthritis, asthma, and diabetes were perceived as more acceptable/less severe and cerebral palsy and mental retardation were seen as the most severe.

Olkin and Howson (1994) found similar results in two separate studies regarding images of physical disabilities. The first study surveyed a sample of undergraduate college students and the second study replicated the first but surveyed Social Service workers. The research was designed to examine the students’ and workers’ attitudes toward people who do have disabilities and the images evoked from the phrase “disabled person.” Rankings of the disabilities were obtained by asking respondents the level of intimacy they would consider for each of thirteen disabilities listed including, but not limited to: leg brace, limp, amputee-arm, deaf, and blind. Though there were limitations within the studies, namely low response rates, the findings indicated that there was a stable hierarchy of acceptance of disability between the two groups, students and Social Service workers. The way in which disabilities were viewed in these investigations is consistent with the aesthetics model, which suggests that the more a physical disability causes the body to deviate from the societal frame of a whole or beautiful body, the lower the perspective or position the disability receives (Livench, 1988; Olkin & Howson, 1994). This has important implications for disability studies and diversity training. According to the authors, “it is no longer appropriate to target the generically-labeled ‘disabled’” (p. 93). Rather, it is important to expose professionals to images, perceptions, and misconceptions about specific disabilities.

In addition to the perceptions of types and severity of disabilities as variables in influencing attitudes, the emphasis of many counselor education programs is also an important predictor in influencing mental health counselors' attitudes toward people who have disabilities. Though there are a number of contradictions in the literature regarding the positive or negative nature of counselor attitudes toward people who have disabilities (e.g., Elston & Snow, 1986; Kaplan, 1982), it has been found that rehabilitation counselors tend to possess more positive attitudes than their counseling counterparts in other disciplines (Carney & Cobia, 1994; Martin, Scalia, Gay, & Wolfe, 1982). To determine the impact of counselor education program emphasis on counselors' attitudes toward people who have disabilities, Carney and Cobia (1994) examined 190 master's level counselors-in-training from three counseling disciplines: rehabilitation counseling, school counseling, and community counseling. In this survey investigation, they also considered amount of experience in counseling. Results indicated that the counselors-in-training on the whole had more positive attitudes than the normative sample, and rehabilitation counselors possessed considerably more positive attitudes toward people who have disabilities than students in the other two emphasis areas. The investigators found no significant difference, however, between the counseling students at an earlier phase in their training than students at later phases. Limitations of the study included having more "beginning" students ($n = 120$) than students who have been in the program for a longer period of time, and the results cannot be generalized to those counselors in the field. The results of this study, however, provided important information for counselor education programs. Specifically, the researchers postulated that students tend to reflect more positive attitudes and beliefs about the populations with which they will be working.

Training and Attitudes toward People with Disabilities

Based on the preceding empirical findings, there is evidence that suggests education and contact are among the most important variables for promoting attitudinal change and improving effectiveness of counselors who work with clients who have disabilities. This insight was validated in a self-report survey study of school counselors who were members of American Counseling Association, worked in schools, and graduated from counseling programs between 1994 and 2000 (Milsom, 2002). The purpose of the investigation was to examine recent trends in school counselor education, but using the random sample from ACA may not have been representative of all school counselors going through training during the 1994 to 2000 period. Also, the findings could not be generalized to those who did not respond to the survey. Despite these limitations, Milsom (2002) found that the participants in this study consistently indicated that they received very little in the way of training regarding disabilities related issues while in their training programs. The author also demonstrated that the participants overwhelmingly indicated feeling only “somewhat prepared” to provide services to their students who have disabilities. Finally, Milsom, pointed out those school counselors who participated in this study felt better equipped to provide services to students with disabilities when they received more information and had exposure to students with disabilities.

Education

There were several studies conducted during the past decade focusing on the educational element as a necessary component for promoting positive attitudes of professionals. In their investigation comparing Chinese students in rehabilitation and business programs, Chan, Lee, Yuen and Chan (2002) posited that a lack of information and exposure to people who have disabilities encouraged negative attitudes “by creating anxiety and confusion” among those who do not have disabilities (p. 325). Though this multiple, non-equivalent group design investigation

used a relatively small sample (73 rehabilitation students and 107 business students), the results indicated important considerations for professions outside of rehabilitation. The two groups took pre and post-test assessments during the course of the investigation. From these two surveys, it was found that the rehabilitation students had consistently more positive attitudes toward people who have disabilities than did business students. However, business students who had prior experience with people who have disabilities tended to have more positive attitudes than their peers who had no previous exposure. The business students were all full time students but did not have any course work during their three year program related to disabilities, nor did they have any structured opportunities to have contact with people who have disabilities. The rehabilitation program, on the other hand, offered a clinical opportunity to work with people who have disabilities during the third year. Although the rehabilitation program offered the clinical exposure to people with disabilities, the investigators determined that one of the most impressive elements of this study was that the academic studies during the first two years of the rehabilitation program drew out positive effects on the students' attitudes even before they participated in the clinical aspect of the program. As such, Chan et al. (2002) suggested that information about people with disabilities, as well as opportunities for exposure, should be incorporated into business and other curricula.

Hunt and Hunt (2000) also studied attitudes of rehabilitation majors and business majors toward people with disabilities. Their investigation, which took place in the United States, resulted in similar outcomes to the Chan et al. (2002) investigation. Limitations of this study also were similar to those inherent to any survey investigation. That is, survey data tend to reflect how respondents think they would react to a given situation rather than how they would actually behave. This study also was limited in that it predominantly incorporated Caucasian participants. Given the results from this study and the results of previous research, however, the Hunt and

Hunt reported that the attitudes of the sample were consistent with those of other undergraduates. In addition, they determined that gender was another contributing factor in professionals' attitudes toward people with disabilities. Since rehabilitation majors were likely to be older, female, and have had more previous exposure to people with disabilities, the overall results were not surprising. Based on the study's findings, Hunt and Hunt, like Chan et al. (2002), suggested that opportunities for exposure to people with disabilities should be incorporated into curricula. The authors went on to suggest that those in the rehabilitation counseling field can also play an important role doing more networking and outreach with others within the counseling profession as well as with the community in general.

Barrette and Pullo (1993), unlike Chan et al. (2002), expressed concern about using certain exercises that expose students to people who have disabilities, citing that, if not met with the appropriate support, these opportunities can in fact be miseducative and reinforce prejudicial ideas about people who have disabilities. Therefore, they focused their efforts predominantly on the effects of information and knowledge on students' attitudes towards people with disabilities. In their study, Barrette and Pullo (1993) conducted pre and post course assessments from undergraduate students in rehabilitation studies over a five year period. Each time their class entitled, "The Handicapping Experience," was offered, the researchers administered the Attitudes Towards Disabled Persons Scale – Form A (ATDP-A) the first week and the last week of the class. In addition to their class lectures and a mid-term and final exam, the students were required to do the following exercises: a computerized simulation of wheelchair usage; a field visit to complete an accessibility survey of a building; a "handicapped" simulation and report; and an interview with an individual with a disability, or a comparable book report. Although they reported that the ATDP scale had been found fakeable in previous research (i.e., Hagler, Vargo, & Semple, 1987), Barrette and Pullo determined that the students overwhelmingly increased

their positive attitudes by gaining accurate information about people with disabilities. Even if the students did distort their answers on the assessment as a way to “look good for the instructor,” the researchers suggested that “... students in this study demonstrated a better knowledge of what ‘positive attitudes’ were on the posttest, indicating that attitudes indeed had changed” (p. 124). Based on this information, the researchers suggested that along with appropriate and accurate information regarding disability, attitudes toward people with disabilities can be positively influenced when students are exposed to experiences that are structured and maintain appropriate elements of challenge and support.

Without having accurate information about disability issues, counselors take the risk of negatively affecting their counseling relationships. This lack of awareness can perpetuate clients’ feelings of being marginalized and negated (Kemp & Mallinckrodt, 1996; Olkin, 1999). Kemp and Mallinckrodt (1996) considered the implications of therapists’ level of information and understanding about people who have disabilities on their clients. In their study, the researchers investigated differences between therapists who reported previous training in disability issues with those who had not had focused disability training (e.g., course work, workshop, or in-service training) focusing on therapists’ case conceptualization, treatment planning, and evaluation of the severity of the problem. Participants were asked to view one of several videotapes with each tape portraying a different client being seen for sexual abuse or sexuality counseling. Some participants viewed videotapes of clients with disabilities, while others watched tapes of clients without disabilities. After viewing the tapes, the participants took the ATDP-A, Marlowe-Crowne Social Desirability Scale (M-C SDS), and the Anticipated Course of Treatment Questionnaire (ACTQ; Kemp & Mallinckrodt, 1996). There was no significant correlation found between the ATDP and the M-C SDS, which demonstrated the therapists were not subject to answering the ATDP in a socially desirable manner.

The researchers established that therapists who had received some prior training in disabilities issues demonstrated significantly more positive attitudes than their counterparts who had not had prior disabilities issues training. Based on the ACTQ, the researchers also found that therapists who received prior training were less biased towards people with disabilities in case conceptualization. To rule out training effects for one query, the investigators compared subjects (reporting prior training and no prior training) who viewed tapes of clients with disabilities. Though there was no significance found between the groups, the researchers did find a trend showing that those with prior training were more likely to give a higher priority to issues important when working with clients who have disabilities (e.g., anger, dependency issues, and belongingness issues). Finding a trend rather than significance may be due to the relatively small sample size. However, the implications for training are imperative. The researchers stressed that working effectively with clients who have disabilities and understanding ideas related to disability reach beyond providing accessible services to clients; rather, these skills are also ethical concerns (Hosie, Patterson, & Hollingsworth, 1989; Kemp & Mallinckrodt, 1996).

Simulation

To enhance students'/participants' understanding of disability issues, educators and program trainers often implement simulation exercises as part of their training. Simulation exercises range from spending a few minutes to several days in replicated disability scenarios (e.g., putting Vaseline on glasses; going around with a simulated visual impairment; using a wheelchair for mobility to maneuver around campus or town). To increase sensitivity and awareness toward students with disabilities, one northeast university implemented a program for undergraduate students and faculty (Wurst & Wolford, 1994). The program consisted of three components: disability simulation, classroom activities, and bringing speakers to campus. According to Wurst and Wolford (1994), the program was found to be beneficial to university

community members by improving their understanding of some of the basic contextual issues with which students with disabilities contend on a daily basis.

Simulation exercises also have been applied to rehabilitation counseling programs with the intention of improving rehabilitation counseling students' attitudes toward people who have disabilities. Though simulation exercises are used in a variety of training programs, Grayson and Marini (1996) suggested that there is limited research regarding changes in individuals' attitudes towards people who have disabilities that occur as a result of simulation experiences. Therefore, they investigated in a quasi-experimental study the impact of a one-time simulation experience of students in rehabilitation studies class and compared their responses to students who did not do simulation exercises but participated in the class during another school year.

The pilot instrument used in this study was researcher-designed and was based on one of the researcher's own experiences of having a disability. This instrument, though based on survey construction guidelines (i.e., Antonal & Liveneh, 1988), may have been limited in its generalizability. Nonetheless, the researchers found statistically significant correlation differences between the two groups in terms of how the participants' viewed persons with disabilities. Those in the simulation group stated that, after the exercise, they could understand why people with physical disabilities have such difficulty in society. However, the researchers also found disturbing responses from several of these same participants. Several of the participants suggested that they would actually kill themselves if they were to experience a disability that required them to use a wheelchair for mobility. As a result, Grayson and Marini (1996) cautioned counselor educators of the potential harm that could be done to clients if counseling students are not also exposed to accurate information about disability related issues and concerns. Overall, the researchers suggested this type of exercise can indeed raise the level of sensitivity and improve attitudes toward people with disabilities.

Because there is a potentially miseducative component to simulation exercises that can ultimately impact the effectiveness of the counseling process, French (1992) cautioned trainers about the ills of this type of training exercise. She suggested that simulation exercises often provide false or misleading information about the experiences of people who have disabilities. In addition, she believed they typically instill negative attitudes, rather than providing a springboard for promoting positive attitudes toward people who have disabilities. Finally, French (1992) contended that simulation exercises fail to reproduce disabilities accurately. As a result, they tend negate the ongoing societal and physical barriers people who have disabilities experience on a daily basis and how people with disabilities employ coping strategies and skills to face these ongoing barriers. Even with these warnings, simulation exercises are used in a variety of training programs; and with proper consideration of ethics, structure, and consequences of such programs, participants of such exercises increase their insight into *some* of the challenges faced by individuals who have disabilities (Barrett & Pullo, 1993; Grayson & Marini, 1996; Lofaro, 1982; Pentland, Hutton, MacMillan, & Mayer, 2003).

Contact

In addition to incorporating simulation into training programs, some training programs offer the opportunity for participants to interact and have structured contact with people who have disabilities. Having contact with and accurate information about people who have disabilities can diminish negative attitudes, promote more positive perspectives of people who have disabilities (Wright, 1988), and influence the effectiveness of services by those in the helping professions (Fish & Smith, 1983; Gilson & DePoy, 2002; Marshak & Seligman, 1993). In a study of baccalaureate rehabilitation nurses at different points in their programs, Biordi and Oermann (1993) found that participants who had had previous rehabilitation exposure in their program, prior to taking part in a rehabilitation nursing conference focusing of disability issues,

scored higher on pre- and posttests of the ATDP-O than students who had not had any prior contact experience.

However, having contact with people who have disabilities can also have negative effects on individuals' attitudes towards people with disabilities. Some opportunities for contact have been found to uphold or encourage negative attitudes (Wright, 1988; Yunker, 1988). In these situations, fear is instilled and stereotypes are reinforced (Barrette & Pullo, 1993). According to Makas (1988), there is a great deal of stress that occurs when people with disabilities and people without disabilities interact, and this stress may indeed further perpetuate negative attitudes toward people with disabilities.

Makas (1988) studied how people with disabilities and those who did not have disabilities wanted to be treated by the other. This study included three distinct samples of participants: respondents who had disabilities, respondents who did not have disabilities but worked in disability-related professions, and those who had not disability and worked in fields not directly related to disability. To offset the possibility of faking, students were also recruited to take the survey two times, once answering it honestly and once trying to fake-well. Each participant was asked to respond to the Issues in Disability Scale (IDS; Makas, Finnerty-Fried, Sigafoos & Reiss, 1988).

The results of the study indicated there was a significant difference in how people with disabilities and people who do not have disabilities perceived what constitutes positive attitudes toward people with disabilities. People with disabilities considered positive attitudes as a channel to promote advocacy towards civil rights and social systems equality. Their counterparts' positive attitudes, on the other hand, reflected the need to be nice or helpful, which ultimately maintains people who have disabilities in disadvantaged positions. As a result, people with disabilities may view these attitudes as demeaning when in fact they are thought to be positive

attitudes by those who do not have disabilities. There are several implications from this study for training. First, people with disabilities need to be involved in training others so that attitudes and standards can be identified and defined. Makas (1988) also suggested that people who have disabilities should be involved in the development and execution of research to alleviate the level of interaction strain that is experienced by those who never have had contact with people who have disabilities. In general, Makas maintained the importance of people with and those without disabilities to learn to communicate clearly about their expectations, which is particularly important when one considers the potential impact that powerful negative emotions have in overtaking the communication process. In emotionally laden communication, “the *content* of the correction is likely to be lost” (p. 59). As a result, neither parties’ expectations are met and barriers between them ensue.

Combined Approaches

Yuker (1994) suggested that “research into attitudinal change should first examine prior attitudes and explicate the combinations of specific types of contact or information that are most effective with all populations” (p. 17). Several training strategies for enhancing and improving attitudes toward people with disabilities have been explored in this section. In each of the studies that explored these various strategies (education, simulation and contact), however, the researchers also indicated that it was necessary to incorporate a combination of the strategies to truly provide the participants with the most valuable opportunity for learning about people who have disabilities and changing their attitudes (e.g., Barrette & Pullo, 1993; Chan et al., 2002; Makas, 1988). The combined effect of obtaining accurate information along with having ample opportunities for exposure or contact with people who have disabilities generates the most positive attitudinal change (Lee & Rodda, 1994).

Miller and Cordova (2002) explored the effectiveness of combining information with contact to people with disabilities for improving students' attitudes toward this group. Participants in the study were required to have 25 direct contact hours in recreational or physical education programs with people with disabilities. The participants were exposed to individuals who had a variety of disabilities (e.g., traumatic brain injury, visual impairments, multiple sclerosis) in activities such as, hunting and fishing, Special Olympics, and adapted physical education in the school. In addition to a demographic survey, participants were asked to complete the Interactions with Disabled Persons Scale (IDP; Gething, 1991) at the beginning and then at the end of the course. The results of the study indicated that the participants had significantly more positive attitudes toward people with disabilities after taking the course and having contact with individuals with disabilities. The change in attitudes, according to Miller and Cordova (2002) are both socially and professionally meaningful. That is, with more positive attitudes, the participants in this study will potentially have more successful interactions and inclusion experiences with people who have disabilities.

Even with information regarding the importance of changing and enhancing attitudes of helping professionals toward people with disabilities, counselor training programs often skirt or ignore issues of people with disabilities (Gilson & DePoy, 2002; Milsom, 2002; Olkin, 2002). As Bluestone, Stokes and Kuba (1996) found, graduate programs in psychology cover disability issues less than any other group of human diversity. More recently, there has been a growing trend to include disability within the frame of multicultural counseling. Multicultural counseling, which once focused on race, ethnicity, and racial identity (Allison et al., 1994) has broadened its concepts of multiculturalism to include the intersections of cultural factors such as disability (Arredondo et al., 1996; Fuertes & Brobst, 2002).

Multicultural Counseling Competency

As this country continues to become more multicultural, multiethnic and multilingual (Hill, 2003; Holcomb-McCoy & Myers, 1999), those in the counseling professions are challenged to continue to bring attention to the importance and necessity of being responsive to multicultural issues in research, training and practice (Constantine & Ladany, 2001; Holcomb-McCoy & Myers, 1999; Ponterotto & Alexander, 1996). From these challenges, models of multicultural counseling competencies have been developed (e.g., Arredondo, et al., 1996; Sadowsky, Taffe, Gutkin, & Wise, 1994; Sue, Arredondo, & McDavis, 1992). Despite coming from different researcher points of view, each current model features perspectives of the three primary dimensions from the Cultural Competency Model (CCM; Sue et al, 1982): knowledge, awareness, and skills, which have been found to be necessary to work effectively with an increasingly diverse population (Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994). The original CCM was expanded to include thirty-one specific competencies and was designed within a 3 x 3 matrix comprised of three dimensions: knowledge, awareness, and skills, and three counselor characteristics: awareness of own cultural biases, values, and awareness; awareness of clients' worldviews; and culturally specific appropriate counseling interventions (Arredondo, et al., 1996; Ponterotto & Alexander, 1996; Sue et al., 1992). In 1998, the list was further expanded to 34 competencies but maintained the basic organization of the previous format (Fuertes et al., 2001; Sue et al., 1998, as cited in Fuertes et al., 2001). Assumed in most multicultural counseling competency models is that counselor self-awareness and sensitivity to cultural diversity issues facilitates the counseling process (Arredondo, et al., 1996; Arredondo & Arciniega, 2001; Ridley et al., 1994; Sue et al., 1992).

Traditional counseling theories and methods typically taught in most counselor education programs have been criticized as being ethnocentric and not useful as intervention strategies

when working with diverse populations (Corey, 1991; Hall, 1997; Hill, 2003; Pedersen, 1997; Sue, et al., 1992; Sue & Sue, 1990). In fact, many of the traditional Western models have demonstrated major limitations when working with racially and ethnically diverse clients (Corey, 1991). Because culture is a crucial element within the counseling process, integrating the multicultural competencies framework throughout the traditional theories lends itself to making the theories considerably more effective when working with diverse populations. In addition to considering the integration of multicultural counseling competencies into many traditional theories of counseling, there have been theories of multicultural counseling developed with this purpose in mind. Though there is not one unified theory of multicultural counseling, the Multicultural Counseling and Therapy (MCT; Sue, Ivey, & Pederson, 1996) is the most prominent at this time and has continued to gain recognition within the counseling field (Lewis, Lewis, Daniels & D'Andrea, 1998). This meta-theory was developed to include the cultural dimension into the counseling process. As stated by Lewis et al. (1998),

... many theoretical and practical considerations addressed in this model apply particularly well to the counseling profession, especially in light of the rapid cultural diversification of the United States and the increasing need for counselors to implement culturally specific approaches. (p. 137)

Whatever the framework, it is clear that there is a pressing need for multiculturally competent counselors. In addition, given the changing demographics of our society, the implications for training competent counselors are far reaching.

The Need for Multicultural Competence

“Multiculturally competent counselors are professionals who possess the necessary skills to work effectively with clients from various cultural/ethnic backgrounds” (Holcomb-McCoy & Myers, 1999, p. 294). Though this definition of culturally competent counselors seems

simplistic, multicultural counseling competence is a rather complex, multidimensional concept (Baruth & Manning, 1999; Constantine & Ladany, 2001; Sue, 2001). As such, the development of counselors who are able to work effectively with diverse populations is an impressive and important charge. Unfortunately, many counselor education programs have not been able to meet the challenge of providing the necessary training to counselors regarding issues that relate to ethnic minorities at a pace consistent with the growth of our diverse population (Sue & Sue, 1990).

One of the consequences of this deficiency is that counselors enter the field lacking the skills necessary to handle ethical issues presented by their racial and ethnic clients with sensitivity (Pedersen, 1997; Sadeghi, Fischer, & House, 2003). Though Pedersen (1997) warns that codes of ethics can reflect the moral standards of the majority group, professional codes of ethics guide professionals' counseling practices (Baruth & Manning, 1999). The interaction between the counselor and the client produces a power differential, even when working within more contemporary constructivistic or collaborative frames. According to Baruth and Manning (1999), "ethics infractions will persist until counseling faculty and the content of counseling courses reflect cultural pluralism" (p. 66). As such, there is an ongoing need for training programs to include ways of teaching multicultural and ethical counseling practices to facilitate students' understanding of the role of diversity in our society and provide a medium for them to develop multiculturally competent skills.

Another consequence of having insufficient training for counselors regarding issues relating to racial and ethnic minorities is the potential for maintaining the counselors' biased attitudes. In a study examining the development of a multicultural social desirability scale, Sadowsky, Kuo-Jackson, Richardson, and Corey (1998) found that counselor attitudes were significant in determining how counselors viewed their multicultural clients. They ascertained

that the multiculturally competent counselors showed a preference for collectivism and externality versus the more inherent White American inclination toward individualism and internality. They also determined that the multiculturally competent counselors' propensity toward sociability was in keeping with the group orientation preference of many racial and ethnic minority people. These findings supported the previous research (i.e., Pope-Davis & Dings, 1995) demonstrating only minimal multicultural competencies were learned or enhanced through workshops, but multicultural counseling courses and practical experiences with minority populations contributed significantly to counselors' perceived multicultural competencies. Therefore, to truly be able to work most effectively with racial and ethnic minority clients, it would seem that course and experiential multicultural training is the most valuable tool in the counselors' counseling "toolbox." Sadowsky et al. (1998) went on to say that

multicultural training could impress on counselor trainees that in addition to their belief in the personal control over their individual endeavors, their recognition of alternative worldviews of minority groups might help them to initiate innovative counselor behavior as well as advocacy in the social action area, practices considered to contribute to multicultural counseling competencies. (p. 262)

The importance of having multiculturally competent counselors who can determine ethical modes of working with their culturally and racially diverse clients and counselors whose attitudes do not interfere with their counseling services, but rather enhance their work with minority populations, goes without argument. However, this line of reasoning can not truly be achieved unless researchers and educators also consider clients' perceptions of the services they are receiving. Over the past decade there has been an increase in the work focusing on the competencies necessary for counselors to work with our society's growing diverse populations (Arredondo & Arciniega, 2001; Hill, 2003; Holcomb-McCoy & Myers, 1999; Reynolds, 2001).

According to Fuertes and Brobst (2002), however, investigating how the competencies actually work in the therapeutic process had been missing in the literature. Therefore, they designed an exploratory study to investigate how counselors' multicultural competencies presented themselves in the counseling process. In this investigation, they recruited counseling students who were involved in personal counseling to participate in this study. The students were to report the race, gender and educational level of their therapist and the number of sessions in therapy. In addition, they were asked to complete the Cross-Cultural Counseling Inventory – Revised (CCCI-R; Lafromboise, Coleman, & Hernandez, 1991), the Counselor Rating Form – Short (CRF-S; Corrigan & Schmidt, 1983), the Barrett Lennard Relationship Inventory (Barrett-Lennard, 1962), the Miville-Guzman Universality-Diversity Scale – Short (M-GUDS-S; Fuertes, Miville, Mohr, Sedlacek, & Gretchen, 2000), and the Counselor Evaluation Inventory (CEI; Linden, Stone, & Shertzer, 1965). Because this was an exploratory study, there were many limitations to it: use of graduate students in counseling training who were being seen by a therapist; small number in this study also dissuades one from making generalizations to the general population; not all data were collected particularly in regards to the therapists' demographic information; and most of those receiving counseling services and the therapists, themselves, were predominantly Euro American.

Despite these limitations, the researchers found three significant results of client perceptions of their therapists' multicultural competencies. First, Fuertes and Brobst (2002) found the clients' perceptions of the therapists' overall level of competence with their therapeutic orientation was a strong predictor of the therapists' multicultural competence. Second, the study showed that clients' perceptions of their therapists' multicultural competence accounted for a significant amount of variance of the clients' satisfaction. That is, the higher the perceived multicultural counseling competency, the higher the client satisfaction. Finally, the research

indicated that, though the multicultural competencies were important to both White Euro American and minority clients, they were considered more important to minority clients than their White Euro American counterparts. This is particularly telling considering that most of the minority clients in this study had therapists who were in fact White Euro American. As can be seen from this study and from the information related to the ethics of multicultural counseling and how counselor attitudes can impact the counseling process, multicultural counseling training is paramount if counselors are to work with and provide appropriate and effective services to those within a culturally diverse society.

Multicultural Training

As has been mentioned previously, there is concern regarding the level and quality of multicultural training that occurs in counselor education and similar human services programs (Sue & Sue, 1990). However, as attention to multicultural issues has increased over the past ten years, so have the number of multicultural counseling workshops and education programs that teach courses in this area (Arthur & Achenbach, 2002; Pope-Davis & Dings, 1995). Despite this attention and the appeals made within the literature for counselors to be more culturally sensitive, there is little information available to direct counselors and counselor educators how to achieve this goal (Ridley et al., 1994). One reason for this lack of information is that the standards are often established from conceptual or theoretical perspectives rather than coming from empirical research (Constantine & Ladany, 2001).

Concerns for a lack of “how to” information notwithstanding, “... diversity is not simply an issue of proving the liberal, humanistic, and moral perspective ...; it is an issue of ethics and conduct within a profession that affects more than 50% of the population” (Hall, 1997). Consequently, CACREP and the APA accrediting boards have mandated multicultural

training be implemented into accredited training programs (Hall, 1997; Holcomb-McCoy & Myers, 1999).

As was mentioned previously, efforts considering cultural competency training have until recently primarily focused on issues of ethnicity and race (Allison et al., 1994) with marginal attention being given to individuals belonging to other minority groups, especially people who have disabilities (Bluestone et al., 1996). This brings to question, then, the extent of exposure students receive about diversity and how programs prioritize diversity studies within programs (Bluestone et al., 1996). Because there are many competing definitions of multiculturalism within various counseling organizations (Holcomb-McCoy & Myers, 1999), it is often difficult to determine how multiculturalism is defined and how it should be approached in the various programs (Arthur & Achenbach, 2002).

There are many parallels between issues pertaining to multicultural groups and issues affecting people who have disabilities such as bias, prejudice, and discrimination (Kemp & Mallinckrodt, 1996; Livneh, 1988). Among the differing perspectives of multiculturalism, the common thread, however, is that clients deserve to be treated with respect and dignity and deserve competent services. As with programs designed to improve attitudes toward people with disabilities, experiential learning has been used to raise knowledge, understanding, and sensitivity to multicultural issues. This teaching approach has also been used for bridging the gap often found between theory and practice (Arthur & Achenbach, 2002; Pope-Davis, Breaux, & Liu, 1997). Arthur and Achenbach (2002) suggested that experiential learning is not meant to emulate a person's true experience; rather, it is to help students develop cultural empathy and awareness of others' worldviews. To truly have a respect and awareness for clients requires understanding of their individual worldviews, or their individual ways of making meaning. There is a theoretical perspective that guides this understanding, cognitive developmental theory.

Cognitive Developmental Theory

While information and contact have been shown to be important determinants in influencing counselors' attitudes toward people with disabilities and their multicultural competencies, many other characteristics have been studied (e.g., race, ethnicity, gender, age). Though most of these variables have yielded non-significant or relatively low correlations with attitudes toward people with disabilities (Yuker, 1994), there have been significant correlations found with some of these variables in the study of multicultural competencies (Holcomb-McCoy & Myers, 1999; Ladany, Inman, Constantine, & Hofheinz, 1997). Counselors' psychological development, however, has received little consideration in research regarding both counselors' attitudes toward people who have disabilities (Millington et al., 1994; Strohmer et al., 1983) and counselors' perceived multicultural counseling competencies (Ridley et al., 1994).

Cognitive developmental theories describe people in terms of their thought processes, how these processes influence their behavior, and how they make meaning from their experiences. They also focus on how an individual's thinking changes from one point in development to another (Santrock, 2002). Individuals are capable of cognitive development across the life span, and the impetus for development is based on an inherent motivation to construct meaning from one's life experiences (Kegan, 1982). This conceptualization is based on Lewin's (1935) premise that behavior is a function of the person and environment ($B=f(p/e)$). No single theory, however, sufficiently characterizes the overall framework for understanding human development (Paisley & Peace, 1995; Sprinthall, 1978, 1994). Therefore, a number of theorists have proposed models representing various domains of cognitive development over the years (e.g., Belenky, Clinchy, Goldberger & Tarule, 1986; Kohlberg, 1976; Loevinger, 1976). Though they represent different domains, or focus on different characteristics of human

development, these theories of cognitive development share eleven central assumptions about human development.

1. As has been mentioned, the individual's development is based on the motivation to attach meaning to their experiences. This assumption asserts that the motivation is intrinsic and drives the individual's desire for mastery and competence (Sprinthall, 1994). As a result, the individual is not a passive recipient of their experiences because the developmental patterns assist individuals attribute meaning to their experiences and ideas.
2. In each domain, the sequence of development occurs in stages, or structures of thinking. These stages represent the individual's current desired level for understanding their environment. Thus, individuals are more capable of understanding those stimuli that correspond to their current level of cognitive complexity (Lewis, Lewis, D'Andrea, & Daniels, 1998).
3. Stages are qualitatively different from one another (Santrock, 2002; Sprinthall, 1978). According to Sprinthall (1978), each stage is unique and separate from the other domain stages; yet, at the same time, each stage is dependent on the previous one. For each succeeding stage builds upon the ones that have come before it in a hierarchical manner. Consequently, individuals at different stages of development have qualitatively different world views than those at other stages.
4. Very closely related to the previous assumption, this assumption posits that development is hierarchical and sequential rather than a "unilateral unfolding" (Sprinthall, 1978, p. 3). Development proceeds from less complex stages to those stages that are more complex. Movement from one stage to the next is characterized by structured to more abstract or flexible thinking (Holloway & Wampold, 1986; Paisley & Peace, 1995).

5. The direction of the sequence is considered to be invariant and irreversible (Gielen, 1991).

As was discussed previously, each stage builds on the previous stage. Therefore, the basis of this assumption is that individuals cannot skip stages in the sequence. Rest (1994) suggested that because each new stage is an expansion of the previous one the sequence of the stages is fixed. In addition to being invariant, stages are irreversible. Once an individual achieves a level of cognitive complexity, he or she will not return to a modal level at a less complex level.

6. Though there are intrinsic drives toward development, growth is not automatic. Rather, development takes the appropriate interaction of the individual in his or her environment for stage change to occur (Paisley & Peace, 1995). According to Sprinthall (1978), an individual needs significant experiences at critical times without which the individual will level off at a stage below his or her cognitive potential.
7. There is a consistent relationship between stage and behavior. Available research has shown that individuals at higher cognitive levels perform more effectively and use more adaptive methods of problem-solving (i.e., Duckett & Ryden, 1994; Holloway & Wampold, 1986; Miller, 1981). A stage, however, in itself does not determine behavior. The choices the person is able to make at the particular stage influences their behavior.
8. This assumption puts forth that cognitive development involves both psychological as well as physiological changes. "Piaget thought that, just as our physical bodies have structures that enable us to adapt to the world, we build mental structures that help us to adapt to the world" (Santrock, 2002, p. 187). This adaptation necessitates that the individual adjusts to his or her new environment. In order to adjust or find balance, the individual must be able to organize and understand information presented in the new environment. This is accomplished through the processes of assimilation and accommodation. Assimilation is the process of trying to

make new information fit into what is already known. Accommodation, on the other hand, is a modification of the individual's organizational system. In this case, the individual must adjust his or her own way of knowing to fit the new experiences.

9. Stage growth is domain specific. In the opening of this section, it was stated that no one theory of cognitive development adequately describes the structure for understanding human development. Development in one domain does not indicate that there is, or will be, parallel development in another domain of cognitive development.
10. Stage classification is modal rather than fixed. According to Sprinthall and Collins (1988), no person is entirely represented in one stage. Rather, an individual may actually function at a stage higher or a stage lower than their modal, or usual, stage.
11. Finally, cognitive development is common across cultures. As was pointed out in an earlier assumption, growth is a result of the meaningful interactions between the person and his or her environment. This includes cultural, ethnic, and racial backgrounds (Lewis, et al., 1998; Sprinthall, 2000). In his review of the literature on cross-cultural universality, Snarey (1985) determined that stage development appeared to be hierarchically invariant and sequential across and cultural settings.

Understanding these assumptions is important when considering counselors who work with populations that have historically experienced societal bias, prejudice and discrimination. Counselors who make meaning, or process information, at higher stages of cognitive development are often more inclined to behave in more compassionate and empathetic ways than counselors who operate at lower levels of development (Sprinthall et al., 2000). Overall, this higher stage development "can lead to a more complex structure for understanding and thinking about self, interpersonal relationships, and ethical decisions" (Paisley & Peace, 1995, p. 87).

Higher is Better

A number of studies substantiate the cognitive developmental view that higher reasoning stages of development is related to more effective functioning. According to Rest (1994),

“better” does not mean that a higher stage subject has more raw intelligence (brain power) or higher moral status, nor does it mean that those at higher stages are entitled to more of the world’s goods and privileges. Rather, higher stages are said to be better conceptual tools for making sense out of the world and deriving guides for decision making. (p. 16)

Benack (1988) investigated, in a series of three studies, counselors’ cognitive developmental levels in regards to the relationship of dualistic and relativistic epistemological considerations with empathetic understanding in the counseling process. Dualism separates knowledge into right and wrong; whereas, the higher stage of development, relativism, looks at things more abstractly and therefore considers there to be multiple truths or perspectives. In the first study 20 volunteer participants from an introductory counseling techniques course were asked to complete the Moral Judgment Interview, a semistructured interview assessment. The interviews were tape recorded and subsequently transcribed. Participants’ were also asked to submit role-play counseling sessions, which were assessed for empathetic understanding in their responses as counselors. The assessment of empathetic responses was compiled by the researcher and three blind raters.

The second study included 18 undergraduate students as participants and the third used 24 undergraduate students. In both of these studies, the Dimensions of Epistemological Thought coding scheme was used and participants were coded as either relativistic or dualistic thinkers. In addition, the participants in the second study were given descriptions of seven counseling scenarios and were asked to write a brief essay from the perspective of the client during the

opening of the counseling scenario. Participant's in the third study were given three of the seven scenarios and were given the same instructions. The researcher and another judge coded the essays.

In all three studies, generalizability is limited due to the extremely small samples used. Also, causal relationships can not be determined by the correlation studies. Despite these shortcomings, the encompassing study's primary strength was that it used several different measures to look at the same construct. Benack (1988) found, in all three studies, a strong tendency for students who think more relativistically about epistemological issues to accurately and with greater frequency express appropriate empathetic understanding. Results were consistent in Study 1, which included counseling graduate students, and in the other two studies that used undergraduate students from various programs of study with no counseling experience.

In an extension to Benack's (1988) studies, Neukrug and MacAuliffe (1993) sought out to determine whether there were similarities between epistemological development, behavior, age and educational level based on Perry's scheme of cognitive development. This study's sample was comprised of 86 undergraduates majoring in human services and 112 graduate students in a counselor education program. Students were given a packet of surveys and asked to return the completed packet within a week. The survey packet included the Measure of Epistemological Reflection (MER), the Opinion Scale, and a demographic form requesting the participant's age, GPA, and graduate or undergraduate standing. After the completed survey packet was returned, the students were shown a video tape of a volunteer-coached client. The participants were then asked to write an empathetic response to 13 of the client statements. All information was coded to ensure participant confidentiality and anonymity. The Carkhuff Empathy Scale was used to rate the participants' empathetic responses to the client's statements by two raters.

Generalizability of this study is limited as the sample came entirely from one college campus. However, results of the study were as was expected. Intercorrelations among epistemological reasoning dogmatism, internality, GPA, age and education level were in expected directions. These results indicated that relativism overall enhances and may actually be the foundation for accurate and appropriate empathetic functioning. The authors suggested that the study's results had important implications for undergraduate instruction. Namely, that opportunity for critical thinking should be incorporated into courses.

In addition to these studies illustrating the cognitive developmental premise that higher is better, there are many studies that specifically support the correlation of higher moral reasoning stages relationship with the enhanced functioning for counselors, teachers, counseling students, child care supervisors, and others (e.g., Chang, 1994; Foster & McAdams, 1998; Reiman & Thies-Sprinthall, 1993; Sprinthall, 1994).

In their study of child care supervisors, for example, Foster and McAdams (1998) implemented and examined the results of a Deliberate Psychological Education (DPE; will be discussed in the next section). In their investigation, the authors developed a training program designed to address the specific challenges faced by supervisors in residential treatment settings for youth. The DPE extended for 14 weeks and was comprised of 35 residential supervisors. In addition to having a shorter time frame than is recommended in the literature for the most favorable developmental gains, there was no control group in this investigation, which may have limited the validity of the findings. Despite these limitations, the study held a great deal of merit in demonstrating significant developmental growth from pre and post training assessments.

The authors/trainers assessed the participant's moral reasoning developmental levels with both the Defining Issues Test (DIT) and the Moral Judgment Interview (MJI; Colby & Kohlberg, 1987). Statistically significant increases were found between the pre and post-testing, indicating

increases in the participants' moral reasoning. Pre and posttest mean gain was 45.80 to 50.71 ($t = 2.19; p < .05$). Advances in the participants' skills were assessed in three ways. First, video taped sessions with group home counselors were used to assess the participants' organization of the supervision session. Second, the authors used the Flanders Interactional Analysis adapted for counseling for three specific purposes: (1) for the participants to rate the observable behaviors of group home counselors and for self analysis of supervision sessions; (2) for trainers to assess the development of complexity and awareness of participants' journal responses and reflections; and (3) for the trainers to assess the participants taped supervision sessions to determine improvement in supervisory skills and balance between direct and indirect responses. Third, the trainers used journals to add to the participants' ability for perspective taking, whereby enhancing their development. The trainers assessed the journal reflections for the participants' abilities to conceptualize the experiences and meaning making of the counselors they supervised.

As with results of the MJJ and the DIT, the trainers viewed marked development in the participants' skills. In fact, the later analysis of the journal reflections revealed an increase in conceptualization on the part of the participants and the supervisees. The participants stated that they enjoyed being able to share a common language with their supervisees and the overall improvements within the supervision sessions. Most importantly, the participants stated that they were far more tolerant and more supportive of their supervisees. These actions demonstrated a higher level of ability which further substantiated the higher posttest scores of the MJJ and the DIT.

Given the increasingly complex challenges facing counselors and the benefit of enhancing one's moral development, as shown in this study and tested in others, it would appear that higher stages of moral reasoning are indeed better than having counselors functioning at lower levels of development. Cognitive development, not an automatic occurrence in one's life,

can be enhanced or encouraged within an appropriate environment. One such way of enhancing an individual's cognitive potential is through the Deliberate Psychological Education (DPE) model.

Deliberate Psychological Education

Deliberate Psychological Education (DPE) is based on Sprinthall and Mosher's (1978) program to further individual cognitive developmental growth potential and is an educational format that provides experiential opportunities to elicit perspective-taking. Incorporating moral problem-solving with an actual role-taking experience along with interaction with peers, seems to facilitate moral judgment development with regular gains (Thoma & Rest, 1986). Traditional education programs do not provide the same necessary components for promoting cognitive developmental growth (Sprinthall & Mosher, 1978). The DPE program's primary function, promoting developmental growth, can be accomplished by utilizing the following conditions: (1) role-taking experience in helping; (2) guided reflection; (3) a balance between action and reflection; (4) continuity; and (5) a climate that is both challenging and supportive (Sprinthall & Thies-Sprinthall, 1983).

Each concept in the DPE is fundamental to the growth process. Role-taking is accomplished by the new role the individual is currently experiencing or by the individual's ability to be placed in new learning experiences (Sprinthall, 1994; Sprinthall, Reiman, & Thies-Sprinthall, 1993). It leads to the individual being able to simultaneously differentiate concepts of self and other (Gielen, 1991). Guided reflection can be emphasized in journaling. This activity is used to help the individual make meaning of his or her experiences from different perspectives by providing a medium for processing feelings. The dramatic effects from this element of the DPE come from the systematic feedback meant to assist the individual make new meaning of the experience (Reiman & Thies-Sprinthall, 1993). There should be ample time between the growth

opportunities for self-reflection to allow for the new information to be assimilated and/or accommodated into the individual's current frame of reference.

According to Reiman and Thies-Sprinthall (1993), there is a need for balance between action and reflection, so as to dissuade an over dependence on either the experience or self-analysis coming from the two previous elements of the DPE. This can be accomplished through the structure of the program itself. Because Piaget's (1950) concept of disequilibrium is imperative for development within this learning experience, support will also be necessary as the individual faces discomfort during the process of giving up old ways of thinking (Peace, 1995). Peace (1995) contended, however, the individual will also need a degree of challenge to assist in the development of new systems for thinking. It is important to be aware of not moving too fast too soon throughout this process, or risk the chance that the experience be miseducative. Finally, continuity, although it seems as though it is a given, is often hard to achieve because of schedules and personal situations that arise. It is, however, imperative to maintain regularity in meeting for growth to be fostered and nurtured.

Evidence regarding the benefits of the DPE Model for enhancing principled reasoning and cognitive complexity has been shown in a variety of professional applications (i.e., Brendel, Kobert, & Foster, 2002; Reiman & Thies-Sprinthall, 1993; Sprinthall, 1994). According to Sprinthall (1994), the higher order skills that are acquired as a result of DPE aligned programs "nurtures humane behavior, ego and conceptual development, and moral judgment" (pp. 96-97).

The Moral Development Domain

Kohlberg's stage model of moral development, a domain of cognitive development, considers how individuals think about interpersonal conflict situations, or their development of thought (Mosher & Sullivan, 1976). Kohlberg's model has to do with moral thinking or judgment, not moral action (Rest, 1994). According to Rest (1994), "Kohlberg turned the

socialization view upside down. Instead of starting with the assumption that *society* determines what is morally right and wrong, Kohlberg said it is the *individual* who determines right and wrong” (p. 2). He developed his theory over a 20 year period stemming from a multitude of field interviews centered on the notion that the individual creates his or her own moral meaning from social events. To determine how people thought about issues of social justice concerns, Kohlberg’s interviews asked questions of the participants regarding stories incorporating characters facing moral dilemmas (Rest, 1994; Santrock, 2002). From results of this longitudinal data, Kohlberg determined that the process of making moral judgments formed a sequential developmental structure (Sprinthall, 1978). Though Kohlberg believed that the sequence was age related (Santrock, 2002), it does not simply unfold according to a genetic blueprint as the product of maturation (Gielen, 1991). Rather, Kohlberg contended that as an individual faces more complex experiences or situations, their cognitive processing structures likewise increase in complexity. Like other developmentalists, Kohlberg (1975) proposed that moral behavior is more consistent, predictable, and responsible at the higher stages of moral reasoning.

There are three levels of moral development divided into six stages. The first level, the preconventional level (Stages 1 and 2), is characterized by the externality of social expectations. Stage 1 focuses on the obedience and punishment avoidance. At Stage 2, moral reasoning is individualistic and the focus is fulfilling one’s own needs. Stages 3 and 4 represent the conventional level in which “conventions, rules, obligations, and expectations are experienced as being part of the self” (Gielen, 1991, p. 30). Within stage 3, the individual develops from a focus on conformity and seeking the approval from external sources to maintaining the social order. Stage 4 is demonstrated by the individual gaining understanding of social order, law, justice, and duty. Finally, in the postconventional level (Stages 5 and 6), the individual moves from a devout law and norms perspective to a perspective in which the person is guided by a social contract, or

the notion of the greater good. See Table 2.1 for more detailed description of Kohlberg's stages of moral development.

Table 2.1
Kohlberg's Stages of Moral Development

Level 1: Preconventional Reasoning

Moral reasoning is principally organized by external rewards and punishments rather than stemming from persons or standards.

Stage 1: Heteronomous Morality: Moral thinking is connected to punishment. There is an objective reality in which the individual tries to avoid trouble from those deemed superior.

Stage 2: Individualism, Instrumental Purpose, and Exchange: Individuals pursue their own interests at this point in development, but they also allow others to also do the same. The concept of morality at this stage is dominant egoism.

Level 2: Conventional Reasoning

At this level, the individual adheres to certain external standards. The idea is that the individual values performing good or right roles so as to maintain conventional order.

Stage 3: Mutual Interpersonal Expectations, Relationships, and Interpersonal Conformity: Individuals place value on trust and loyalty to others as a framework for their moral judgments. The focus, then, is on pleasing others.

Stage 4: Social Systems Morality: Moral judgments are framed on the individual's understanding and showing a respect for laws, duty, and social order.

Level 3: Postconventional Reasoning

At this level, the individual recognizes that there are alternative views of moral action.

Stage 5: Social Contract or Utility and Individual Rights: The duty is structured in terms of contract and a general avoidance of a violation of others' welfare and well-being. The values and rights of others transcend the law.

Stage 6: Universal Ethical Principles: The individual has developed a standard of universal human rights. The conscience is the primary influence. Principles regulate and scrutinize social systems and laws.

Note. A summarization of Kohlberg's Levels of Moral Reasoning compiled from reviews as described by Rest (1994), Santrock (2002), and Sprinthall (1978).

Moral Development Research

This theory has not gone without challenge (Rest, 1994). There have been criticisms of Kohlberg's theory of moral development for its lack of consideration of gender and cultural differences (Gilligan, 1982; Snarey, 1985), negating the role of the family in facilitating a child's moral development (Gibbs, 2003), and the vague relationship between moral behavior and moral judgment (Rest, 1994; Thoma, 1994).

Gender and culture. Gilligan (1982) challenged the validity of Kohlberg's theory denying its supposition that there are similarities between men and women. Unlike the model's theoretical position that all people base morality on issues of justice, fairness, and individual rights of morality, Gilligan postulated that girls and women determine answers to moral issues around the ideas of caring and responsibility. As such, those who operate out of the moral decision making of care and responsibility must understand the context for moral choice and that the moral choice is established by the experiences the individual brings to the situation (Belenky, Clinchy, Goldberger, & Tarule, 1997). According to Rest (1994), there is virtually no support for Gilligan's theory as evidenced in an extensive analysis of moral development research (Rest, Thoma, Moon, & Getz, 1986). In fact, Rest et al. (1986) suggested that Gilligan's claims came about even though she had never completed a systematic review of the moral judgment research on gender difference before she made her claims.

To determine whether there were differences of DIT scores between males and females, Thoma (1984, cited in Rest et al., 1986) performed a meta-analysis of reviewing 56 studies for gender effects. The investigation included a comparison of the effect of gender with those of age and education. Thoma (1984, cited in Rest et al., 1986) performed a two-way ANOVA (gender by age/education levels) and found that age and education were by far more powerful than gender at accounting for DIT score variance (gender, $W = .002$; age/education, $W = .525$). Thoma

also found that the interaction between the two variables to be nonsignificant. Finally, the meta-analysis revealed that there were slight differences in gender scores ($d = .21$). The results indicated that females, not males as was expected, consistently scored higher on the DIT. Rest et al. (1986) surmised, while the results of this study were important in regards to the charges made by those like Gilligan referencing gender bias on measures of moral judgment, the effect size was overall inconsequential.

Another criticism of Kohlberg's theory is that it is culturally biased (Santrock, 2002). While maintaining the position that stage development appeared to be invariant and sequential cross-culturally, Snarey (1985) found that Kohlberg's theory was not entirely universal in all regards. In fact, Snarey (1985) challenged Kohlberg's position regarding traditional folk societies never scoring at a stage 5 and went on to suggest that the higher stages within the postconventional level were primarily based on Western ideologies, thus leaving the descriptions of these stages incomplete. In one study, the moral development of several young male Buddhist monks was assessed (Huebner, Garrod, & Snarey, 1990, as cited in Santrock, 2002). The researchers found that the issues of justice, as defined by Kohlberg, were not important. Rather, their concepts of the role of compassion were not at all captured in Kohlberg's theory.

In their analysis of the use of the DIT in cross-cultural moral judgment research, Rest et al., (1986) found that the similarities between cultures were more remarkable than the cultural differences found in the 20 studies investigated. The authors admitted that there were a number of limitations in their analysis. For example, translations of the DIT from English were not validated prior to use; the studies included small sample sizes; and, the studies were all cross sectional and did not include the benefits of longitudinal investigation. Even when considering these limitations, the examination revealed that the data trends were not disproportionately different than U. S. samples (Rest et al., 1986). Though this theory does not capture all cultures

concepts of morality, it does summarize the moral reasoning is found in many cultures (Sprinthall et al., 2000).

The role of the family and moral development. Moral developmental theory has given little to no attention to the influence of the family process on an individual's moral development. In fact, Kohlberg thought that family influences were unimportant to a child's moral development and that peers or friends provided more appropriate experience to enhance moral development given their comparative social status and cognitive developmental levels (Walker & Henning, 1999). Walker and Henning (1999) found that, in addition to the parents' parenting styles and ego functioning, their moral reasoning level was a predictor of their children's moral development. In addition to their moral development of moral reasoning, parents can contribute to their children's social perspective taking (Gibbs, 2003). Thus, contrary to Kohlberg's position, it would seem that parental and familial influences can indeed enhance an individual's moral development.

Four Component Model of Moral Development

A final criticism of Kohlberg's theory is that, though there is a positive correlation between moral judgment and moral behavior, the degree of the relationship is modest (Rest, 1994). Based on this information, Rest, Bebeau, and Volker (1986) determined that moral development is a multifaceted process and developed a model comprised of four basic psychological processes necessary for moral behavior to occur. The first component is moral sensitivity, which is the awareness of how one's actions affect others. "It involves being aware of different possible lines of actions and how each line of action could affect the parties concerned" (Rest, 1994, p. 23). Because individuals are able to consider another's perspective in this component, it includes empathy and social role-taking skills. Component 2 is moral judgment. This is the area that Kohlberg focused most of his efforts. Moral judgment is how the individual

determines which course of action, or behavior, is morally acceptable. Though it is important, moral judgment is not the only determinant to moral behavior. The third component to the model is moral motivation. This component has to do with the level of importance of one's moral values when they are competing against all other values (i.e., self-actualization or power). Finally, component four involves moral character, which incorporates ego strength. Psychological strength and strength of character do not guarantee competence in the other components of this model, but it is a necessary element to carry out a course of moral action. Rest (1994) concluded that deficiencies in moral behavior could occur within any of the components, and that all four of the components are necessary to influence moral action.

Neo-Kohlbergian approach. In addition to developing the Four Component Model, Rest and his colleagues adapted Kohlberg's theory of moral reasoning to the Neo-Kohlbergian approach (Rest et al., 1999). The Neo-Kohlbergian approach includes several significant differences from the Kohlbergian perspective. First, Rest et al. (1999) made a departure from the concept of hard stages in the developmental process and replace it with the concept of soft stages. With the soft stage concept, the authors contended that there are shifting distributions rather than the staircase metaphor, which suggested that each step is representative of the primary stage from which the person operates. Second, the Neo-Kohlbergian approach designates schema as more concrete and specific than Kohlberg's stages. The third modification as presented by the Neo-Kohlbergian approach is that it does not claim that assessment is of cognitive operations. Instead, the authors suggested that assessments are of concepts of social and role systems. Fourth, whereas the Kohlbergian model postulated the universality of the developmental stages, the Neo-Kohlbergian approach views cross-cultural similarity as an empirical question. That is, morality is negotiated within the context of social interaction. Finally, the Neo-Kohlbergian approach, as projected in the Four Component Model, includes an

expansion of moral behavior to include more than just moral judgment. Moral behavior also is produced through moral sensitivity, motivation, and character.

Though there are differences between the two approaches. The Neo-Kohlbergian approach does maintain several of the core elements of Kohlberg's model.

1. Emphasizes cognition and how the individual makes sense of the world.
2. The notion that there is social construction of basic categories of epistemology (i.e., justice, social order, and rights).
3. The change that an individual experiences is represented as development. That is, that the concepts for understanding of what is considered morally right at one point in time are more cognitively advanced at another (i.e., higher is better in the philosophical sense).
4. There are shifts that occur in the developmental process from conventional thinking (maintaining social norms) to postconventional thinking (morality contributes to others' welfare and well-being, and ideals of cooperation). (Rest et al., 1999)

A Developmental Approach to Counselor Training

When translated to counseling from the cognitive developmental standpoint, counselors who process their experiences at the higher levels of cognitive development are more capable of taking on the perspectives or worldviews of their clients than those counselors at lower or less complex stages of development (Benack, 1988; Brendel, Kolbert, & Foster, 2002; Holloway & Wolleat, 1980; Neukrug & McAuliffe, 1993). Hence, they are also expected to perform with more compassion and empathy than their counterparts at the lower stages (Sprinthall, Peace, & Kennington, 2000; Strohmer et al., 1983). In addition to these characteristics, counselors at higher developmental levels tend to achieve greater efficiency and effectiveness in a multitude of

counseling areas, including: their problem-solving abilities, ability to recognize individual differences, valuing cultural diversity, and being aware and knowledgeable of self (Sprinthall et al., 2000). According to Kaiser and Ancellotti (2003), research on the cognitive development of counselors has also shown that counselors at higher developmental levels possess more competent counseling skills. In fact, counselors with higher cognitive complexity are more capable of case conceptualization and hypothesis formation (Holloway & Wolleat, 1980), understanding client worldviews and being able to consider client concerns from multiple perspectives (Neukrug & McAuliffe, 1993), and greater empathetic communication to clients (Benack, 1988). As this country becomes more pluralistic, it is even more imperative that counselors develop these complex skills and be trained to meet the needs of clients in a diverse society.

Without an organized developmental framework for training counselors, however, programs meant to teach counselors how to work within a diverse and complex society are promoting counselors to use eclectic approaches mostly concerned with secondary prevention (Kohlberg, 1975). "Cognitive development is the key to understanding not only the psychology of morality but also virtually all of the topics in social development that have bearing on counseling practice" (Hayes, 1994, p. 72). Therefore, Kohlberg (1975) proposed the use of a cognitive developmental approach in counselor education. He maintained that this approach provides a focus toward a successively more complex cognitive reorganization of experiences as the goal of counselor education. Rather than teaching counselors moral qualities, Kohlberg maintained that the cognitive developmental approach in counselor education to be an instrumental variable in stimulating motivation to the next stage of reasoning. Accordingly, these higher stages of development, as discussed above, are associated with more competent counseling skills.

Counselor Development and Multicultural Counseling Competencies

Since Kohlberg's call to the counseling field, there have been a number of studies conducted to support the relationship between higher moral reasoning stages and more positive professional behaviors and characteristics for counselors (Peace, 1995; Sprinthall, 1994), teachers (Chang, 1994; Reiman & Thies-Sprinthall, 1993), child care supervisors (Foster & McAdams, 1998) and others. Given the increasingly complex challenges facing our diverse society, it is apparent that there is benefit in promoting higher levels of moral development in those who provide counseling services. There have been virtually no studies, however, connecting moral development with counselors' multicultural competencies for working within our diverse society.

Recently, there have been studies conducted investigating counseling students' and counselors' multicultural counseling competencies and their correlation to moral development. In one study, the relationship between White school counselor interns' levels of moral development, their racial attitudes, and their perceived competencies for addressing the needs of African American students was explored (Milliken, 2004). Using a relatively small sample of 53 counseling students, Milliken (2004) found White school counselor interns with higher moral reasoning levels were more significantly tolerant than those at lower levels of moral development. Those who were more tolerant also perceived themselves as having greater multicultural counseling competence. However, no relationship was found between the counselors' moral development and their multicultural counseling competencies. In another recent investigation, Grothaus (2004) explored the relationship between school counselors' moral development level, their self-perceived multicultural counseling competence level, and their level of participation in clinical supervision. Similar to the previous study, no statistical significance was found between higher moral developmental levels and increased levels of

multicultural counseling competence even when considering the professional development element of clinical supervision (Grothaus, 2004).

In a two year follow-up survey study conducted by Vinson and Neimeyer (2003), the researchers determined, among other important factors, that multicultural training seems to be linked to higher levels of counselors' perceived multicultural counseling competency. This result was similar to other research that demonstrated counselor training as a variable for increased multicultural counseling awareness (Stewart et al., 1998). Despite these findings relating multicultural training to perceived higher order multicultural competencies, no studies have been found showing significant correlations between multicultural training and measures of an individuals' level of moral reasoning (Evans & Foster, 2000; Taylor, 1994). Though the results have not shown significant correlations between multicultural training and moral reasoning, the studies' results have shown relationship "trends" prompting some to suggest further investigation (Taylor, 1994).

In another investigation exploring multicultural experience, rather than training, of 70 college students and moral development, the researchers found a significant relationship between the two variables (Endicott, Bock, & Narvaez, 2003). Though causal relationships can not be determined from these results, the authors indicated that patterns of intercultural development and multicultural experience are related to intercultural sensitivity. In addition, Endicott et al. (2003) found that the depth of the experiences were indicators of moral development. Therefore, rather than implementing what they coined the "whirlwind" approach, the authors suggested that more time should be spent to understand values and worldviews of those from other cultures. Given that people with disabilities are virtually not discussed in multicultural and diversity training programs (Bluestone et al., 1996) brings to attention the question of whether the amount

that is covered is offering any growth potential for the counselor at all particularly for working with this population.

Counselor Development and Attitudes towards People Who have Disabilities

Based on the scant findings showing some patterns or trends linking moral development to multicultural training and multicultural experience, it would seem reasonable that they would also be true when considering opportunities to enhance counselors' attitudes toward people who have disabilities though issues related to this population are not covered in many multicultural training programs. To date, however, no studies were found linking moral development with counselors' attitudes toward people who have disabilities. Most of the literature regarding attitudes toward people with disabilities has focused on assessments of attitudes. Far less has focused on cognitive information processing components of attitudes (Millington, Strohmer, Reid, & Spengler, 1996).

In a study investigating counselors' cognitive information processing, however, Millington et al. (1996) did investigate the correlation between counselors' measures of cognitive complexity and their attitudes toward people with disabilities, as measured by the ATDP-O. Results of this threefold investigation were surprising. Those participants who scored higher in cognitive complexity, a specific domain of cognitive developmental theory considering personality organization, scored low in their attitudes toward people with disabilities. According to Millington et al., people who are more cognitively complex are not measured appropriately on the ATDP or other similar instruments. They also proposed that counselors who were more aware of the realistic differences between themselves and clients were less subject to biases and more capable of making sound judgment throughout the counseling process.

As have aspects of moral development, cognitive complexity, an information processing variable, has also been linked to counselors' capacity to make more accurate hypothesis

formation, more accurate empathic responses, and less diagnostic stereotyping (Holloway & Wampold, 1986; Holloway & Wolleat, 1980; Kaiser & Ancellotti, 2003). Empathy is an important factor when working with diverse populations, including clients who experience disabilities. Counselors who are not able to project appropriate empathetic responses to their clients often demonstrate sympathetic or patronizing interactions which ultimately get in the way of the counseling relationship (Lofaro, 1982). Empathy occurs when a person takes the perspective of another person and is able to put himself or herself in the position of the other person (Gibbs, 2003). In so doing, the counselor must keep check on his or her attitudes toward and views of disability in order to recognize prejudicial assumptions (Sue & Sue, 2003).

Strohmer, Biggs, Haas, and Purcell (1983) investigated the relationship between counselors' level of empathic responses, anxiety, and cognitive complexity in a 2 X 2 X 2 analysis of variance with repeated measures across disability and non-disability conditions. As counselors scoring higher on measures of cognitive complexity also demonstrate higher levels of empathy (Heck & Davis, 1973, as cited in Strohmer et al., 1983), the investigators hypothesized that this would follow suite when counselors are working with people who have disabilities. The Paragraph Completion Method (PCM) was administered to measure the participants' level of cognitive complexity one month prior the intervention. As was expected, there was a significant main effect on empathy with cognitive complexity. In the study, participants were to respond to a series of videotaped vignettes of "clients" who had disabilities and "clients" who did not have disabilities in both low and high states of arousal (clients were actually actors). Two trained independent raters assessed the participants' responses on the Carkuff's Accurate Empathy Scale (AE). Students scoring lower cognitive complexity demonstrated higher levels of empathy to the clients without disabilities who portrayed low anxiety scenarios. The lowest empathy was shown towards clients without disabilities under high anxiety and no differences were determined with

clients who did have disabilities in either high or low anxiety. The empathetic responses to clients by counselors with higher cognitive complexity were almost directly opposite. The researchers determined that client disability is related to the level of empathy when considered with the level of student anxiety and their level of cognitive complexity. Students, therefore, with higher levels of cognitive complexity are more empathetic and less likely to be biased when working with clients who have disabilities.

Though these studies did not discuss moral development, it is important to note that a number of studies have shown a relationship between various domains of cognitive development, including conceptual reasoning and moral development, and positive counselor qualities necessary to meet the needs of their clients (Foster & McAdams, 1998; Holloway & Wampold, 1986; Holloway & Wolleat, 1980; Richardson, Foster, & McAdams, 1998; Stoppard & Miller, 1985). Counselor education training from a cognitive developmental frame can prepare counselors to understand the worldviews of their clients, and the promotion of moral developmental growth seems particularly to be amenable to intervention (Evans & Foster, 2000). One such method of promoting an individual's moral development is through social role-taking, which provides the individual with a catalyst to understand self and other simultaneously (Gielen, 1991).

The Importance of Social Role-Taking

According to Kohlberg and Wasserman (1980), empathy and role-taking are important for both psychological and moral development. In a meta-analysis of role-taking studies conducted by Sprintall (1994), findings indicated that effect sizes of social role-taking were significant on measures of moral development. Role-taking, not to be confused with role-playing, is the psychological process that bridges intellectual understanding and moral judgment (Sprinthall, 1994; Sprinthall, Reiman, & Theis-Sprinthall, 1993). In addition to being important

to moral development, role-taking is considered fundamental to social perspective taking (Gielen, 1991), mutual respect, empathy, and caring (Gibbs, 2003), all essential elements in multicultural counseling competency and enhancing attitudes toward people with disabilities.

Earlier in this literature review, studies described relationships between exposure to and experiences with certain populations to enhanced attitudes toward people with disabilities and increased competencies in multicultural counseling. The interventions incorporating exposure to diverse clients/people were not designed just to give students/learners the opportunity to meet and interact with people different than themselves. These role-taking opportunities were designed to give the learners the ability to take "*into account*" (Gibbs, 2003, p. 3), not just be aware of, another's perspectives, attitudes, and beliefs. This act of placing an individual into a new helping role, one in which the person is encouraged and challenged to understand beyond what is currently comfortable, is an important element in promoting the individual's moral growth (Reiman & Thies-Sprinthall, 1993). Counselors at higher stages of moral development, in turn, are more apt to have more compassionate effective, empathetic, and ethical interactions with their clients.

By increasing their self-awareness and their awareness of others through their moral development, counselors develop competencies in other domains, which ultimately allows for new information to be translated to other areas within their professional practice (Arthur & Achenbach, 2002). For instance, moral development and intercultural development have been shown to be related particularly when multicultural experiences are considered (Endicott et al., 2003). According to Endicott et al. (2003), it is not only having new multicultural experiences but having experiences that require the individual to work within multiple frameworks that promotes flexible thinking, or cognitive development. In achieving this more flexible thinking, the counselor is aware of his or her own cultural values as well as the client's values,

worldviews, and culture, which is in part the goal of training multiculturally competent counselors.

Although individuals with disabilities may be from different racial, ethnic, and cultural minorities, similarities indicate the benefit of using multicultural counseling competency model for training counselors about working with clients who have disabilities. There are similarities between issues pertaining to multicultural groups and issues affecting people who have disabilities such as bias, prejudice, and discrimination (Kemp & Mallinckrodt, 1996; Livneh, 1988). Despite these parallels, there are also significant differences. One specific example is that people with disabilities often do not live in homes or communities with people who share the same minority status; and the perspective of people with disabilities held by those in the community is largely stigmatizing. According to Arredondo et al. (1996), however, “developing multicultural counseling skills allows for appropriate interventions, advocacy, and an effective use of culturally appropriate models” (p. 56), which includes other dimensions of diversity, as disability. As can be seen, there are practical commonalities among these constructs – attitudes toward people with disabilities, multicultural counseling competencies, and moral development; but, there is limited empirical research to determine whether any relationship exists among them. Determining a relationship among these three concepts has important implications for counselor education and training programs designed to prepare effective, competent counselors who will be continuously challenged to work with a growing diversity of clients.

Conclusion

This review of the literature has taken a comprehensive look at attitudes toward people with disabilities, multicultural counseling competencies, and moral developmental theory. It is clear that as our society continues to grow more diverse, counselors will have to continue to develop their skills, awareness, and knowledge to provide effective services to their clients.

Despite this awareness, content regarding clients who have disabilities receives very little attention in counselor education programs and other related trainings (Bluestone et al., 1996; Olkin, 2002). This lack of training translates to counselors entering the field with little or no knowledge of how to best serve their clients who have disabilities. Ineffective services, in turn, serves to further perpetuate the marginalization of people in this minority group.

Though there is an overall lack of training for counselors regarding disability related concerns, there have been a number of approaches that seem to work well in enhancing counselors' and other professionals' attitudes toward people with disabilities. Overall, counselors seem to benefit from having accurate information to regarding people who have disabilities (Carney & Cobia, 1994). Having accurate and appropriate information about disabilities dissuades maintaining the generic label "disabled" and encourages professionals to challenge their perceptions and misconceptions (Olkin & Howson, 1994). Exposing professionals to people with disabilities has also been shown to enhance and encourage attitudes. In fact, counselors who have had previous exposure to people with disabilities were shown to have had more positive attitudes toward them (Kemp & Mallinckrodt, 1996) and more confidence in working with them (Miller & Cordova, 2002). The combination of the two, however, was deemed the most appropriate strategy for improving attitudes toward people with disabilities (Chan et al., 2002).

Presenting accurate information and providing opportunities for experiential learning align with the premise of multicultural competency training. According to Arthur and Achenbach (2002) experiential learning, in particular, is designed to provide counselors and students with an opening in which they can develop cultural empathy and an awareness of others' worldviews. Though the amount of empirical information regarding application of multicultural counseling competencies and its training are still in their infancy (Manese, Wu, & Nepomucceno, 2001), the growing diversification of our society necessitates counselors be trained to meet the challenges

of working effectively and appropriately with their client populations (Arredondo et al., 1996; D'Andrea & Daniels, 1995; Sue et al., 1992).

To meet this challenge training from a cognitive developmental frame is a viable option for preparing counselors to work with diverse clients by assisting counselors understanding of their clients' worldviews. Cognitive developmental theory emphasizes that people's actions are related to their cognitive complexities. Counselors who process their experiences, therefore, at the higher levels of cognitive development are apt to perform more altruistically and humanely than those at lower stages of development (Sprinthall, et al., 2000). In addition, these counselors tend to attain greater efficiency and effectiveness in many counseling areas, including problem-solving abilities, empathy, ability to recognize individual differences, valuing cultural diversity, and being aware and knowledgeable of self (Sprinthall et al., 2000). One such method of promoting an individual's moral development is through social role-taking, or exposure to new meaningful experiences, which provides the individual with a means to counselor self-awareness and an awareness of their clients' perspective, worldviews and cultural values (Gielen, 1991).

Although this review of the literature illustrates a comprehensive examination of attitudes towards people with disabilities, multicultural counseling competency, and moral development in counseling and their commonalties, research on the relationship between and among the three is limited. In response to this limitation, this study will consider the relationships between and among counselors' attitudes toward people with disabilities, counselors' perceived knowledge and awareness of their multicultural competencies, and counselors' moral development. The purpose is to better understand these relationships such that counselor educators and program trainers can use the information gained to more appropriately meet the needs of their students as they prepare (or continue in some cases) to work with diverse clientele.

CHAPTER THREE

Methodology

Introduction

The study of professionals' and students' attitudes towards people who have disabilities has received a great deal of attention in a variety of fields over the past several decades (Hunt & Hunt, 2000). In particular, this research has focused on improving knowledge and awareness regarding this minority group (Grayson & Marini, 1996). Despite the call from those in the field for multiculturally competent counselors who are also well versed in all areas of human diversity (Arredondo et al., 1996; Fuertes & Brobst, 2002; Sue et al., 1992), little of this research has been done in the field of counseling other than in rehabilitation counseling (Olkin, 2002). This study, therefore, was designed to consider this gap in the research and looked specifically at the relationship among counselors' moral development, their perceived multicultural competencies, and their attitudes towards persons with disabilities.

This chapter presents a description of quantitative research and its application to this study, a discussion of participants and sampling procedures, data collection and the instruments used, data analysis, and the ethical considerations associated with the survey method of research used in this study.

Quantitative Method

Quantitative research is defined by Gall, Borg and Gall (1996) as "inquiry that is grounded in the assumption that features in the social environment constitute an objective reality that is relatively constant across time and settings" (p. 767). The overall uses of quantitative methods are to test and verify theory, describe results through statistical analysis to inform the practice, collect data on predetermined reliable and valid measures, and to add body of knowledge to field through replication of study or new inquiry (Creswell, 2003; Trochim, 1999).

To add new information to the current body of literature regarding counselors' attitudes toward people with disabilities, this study considered the relationship among counselors' moral judgment levels and their perceived multicultural competencies with their attitudes towards people with disabilities. Data regarding these variables were collected through a cross-sectional internet based survey method. In order to adequately predict or explain the complex phenomena collected, the variables were considered in multiple regression analyses (Licht, 1995).

Sampling Procedures and Participants

Because persons with disabilities make up the largest minority group in the United States (Olkin, 1999; 2002), counselors will come across individuals and families who experience disability at some point in their practice, if they haven't already. With this in mind, the target population for this study was counselors and counseling students in the United States and was comprised of members of the American Counseling Association (ACA). The ACA is an organization consisting of professionals who work in private and public counseling, education and related services with approximately 52,000 members worldwide (<http://www.counseling.org>).

Members of ACA who were also members of the Rehabilitation Counseling division (ARCA) were excluded from the sample. The reason for excluding the ARCA members from this study was to ensure that a large percentage of respondents would not be representative of rehabilitation counselors, as this group works predominantly with clients who have disabilities. Furthermore, literature has consistently shown that, as a group, they have more positive attitudes towards people who have disabilities than other areas in the counseling profession (Carney & Cobia, 1994; Martin et al., 1982). A random list from all other ACA members was obtained from the ACA database such that a worldwide sample of 999 counselors was selected for this study. Thus, the sample representing this population was a purposeful sample of ACA counselors. As

this investigation focused on counselors and counseling students in the United States of America, fourteen ACA members were excluded from the sample because of their mailing addresses were a country other than the U.S. or its territories ($N = 985$). The goal for this investigation was to secure approximately 120 counselors as participants.

Postcards were sent out on April 10, 2004 to five hundred of the remaining sample to introduce the study and to explain that an e-mail would follow directing the participant how to complete the web based survey. Participants were asked to complete the DIT – short version, the MCKAS, the ATDP-O, the M-C SDS – form C, and a researcher designed Demographic Form. (Instruments used in the study are presented in the Appendices.) With the exception of the demographic form that appeared first on the web based survey, the survey instruments were programmed to appear in a random order to counterbalance testing effects.

From the mass e-mail sent out on April 18, 2004 to the first 500 in the sample, 117 e-mails came back undeliverable. To ensure a larger sample, the remaining 485 participants were e-mailed the introduction letter on April 29, 2004 and were requested to complete the same survey. Of these, 114 e-mails came back as undeliverable. The resulting group was $N=754$. Of this group, $N = 191$ participants submitted completed surveys (25.33% response rate). The sample ultimately included participants of varying ages, racial/ethnic groups, education levels, years of experience, and the areas of focus with differing amounts of multicultural training and disabilities studies training.

Study Participants' Demographics

From these 191 participants (25.33% response rate) who completed all survey forms, 146 (76.44%) were female and 45 (23.55%) were male. These figures are similar to available ACA membership demographic information (females = 66% and males = 23%; www.mglists.com, retrieved May 21, 2004). The ages of the participants ranged from 23 to 74 ($M = 41.35$, $SD =$

12.93, Mode = 26). A total number of 166 participants identified themselves as Caucasian (86.91%), 11 as African American (5.76%), 7 as Hispanic/Latino(a) (3.66%), 4 as Asian/Pacific Islander (2.09%), 1 as American Indian/Alaskan (.52%), and 2 as Multiracial (1.05%, see Table 3.1 for Participants by Race/Ethnicity and Gender).

Table 3.1
Participants by Race/Ethnicity and Gender

Race	Male	Female	Total
Caucasian/ Caucasian European	42	124	166
African American/ Black	1	10	11
Hispanic/Latino(a)	1	6	7
Asian/ Pacific Islander	1	3	4
American Indian/ Alaskan	0	1	1
Multiracial	0	2	2
Total	45	146	191

Note. N = 191. Due to low survey returns from participants of minority race/ethnicity groups, Non-White category is used in future analysis.

The level of counselor education was determined by the highest academic degree attained and was recorded as Bachelor's, Master's, ABD, Doctorate, or Educational Specialist (Ed.S.). Of the 191 participants in this sample, 26 reported having a Bachelor's degree (13.61%), 125 reported having a Master's degree (65.45%), 4 reported having ABD (2.09%), 32 reported having a Doctoral degree (16.75%), and 4 reported having an Ed.S. degree (2.09%).

Level of experience was determined by the number of years the participant had been working in the counseling field. Values were given to those participants who reported their level of experience was from a practicum (practicum experience = .50) or internship (internship experience = .75). For those who reported having zero (0) years experiences, a value of .25 was

given, as these participants had some level of experience (i.e., school, or recently started a position but not yet 1 year). The average number of years in the counseling field was 6.41 years ($SD = 8.37$). Most participants reported to be currently in their Internships or Internship as the highest level of experience.

When asked about their counseling degree focus, 66 reported a mental health focus (34.55%), 45 of the participants reported a community counseling degree focus (23.56%), 41 reported a focus in school counseling (21.4%), 10 reported marriage and/or family focus (5.24%), 8 reported a substance abuse focus (4.19%), and 21 (10.99%) reported “other” (i.e., art therapy, career counseling, college counseling, counselor education, pastoral counseling, and rehabilitation counseling, see Table 3.2 for participants’ degree focus).

Table 3.2
Participants’ Degree Focus

Degree Focus	Frequency	Percentage
Mental Health	66	34.55%
Community	45	23.56%
School	41	21.47%
Marriage and Family Counseling	10	5.24%
Substance Abuse	8	4.19%
Other	21	10.99%
Total	191	100.00%

Note. “Other” included Art Therapy, Career Counseling, College Counseling, Counselor Education, Pastoral Counseling, and Rehabilitation Counseling.

Information regarding how the participants’ received their Multicultural Counseling training was also collected. Of the participants in the study, 66 reported that they received their multicultural training through a multicultural counseling class and multicultural counseling information was integrated throughout their degree program (34.55%), 55 reported receiving multicultural counseling training through a multicultural class in their program (28.80%), 41

reported having multicultural counseling information integrated throughout their degree program, but did not have a specific class on multicultural counseling (21.47%), 23 participants reported that they received their multicultural counseling training outside of their degree program in workshops or other trainings (12.04%), and 6 participants reported having received no multicultural counseling training at all (3.14%, see Table 3.3 for participants multicultural training)

Table 3.3
Participants' Multicultural Training

Training	Frequency	Percentage
Formal Training		
Class	55	28.80%
Class and Integrated	66	34.55%
Integrated in Program	41	21.47%
Informal Training		
Trainings and Workshops	23	12.04%
None	6	3.14%
Total	191	100.00%

The final two demographical categories collected included whether participants had a specific Disabilities Studies course, and whether they had a disability. Of the 191 participants, 144 of the participants reported having had no disability studies in their degree program (75.39%). Whereas, only 47 reported that they had had a course focusing on disability studies (24.61%, see Table 3.5 for participants' disability studies training).

There were 172 participants who reported having no disability (90.05%) and 19 participants who reported having a disability (9.95%).

Instrumentation

The data in this study were collected through the use of a researcher designed Demographics Form, the Defining Issues Test Short Version (DIT – short version; Rest, 1990); the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002); the Attitudes Toward Disabled Persons Scale Form O (ATDP-O; Yuker, et al., 1966); and the Marlowe-Crowne Social Desirability Scale Form C (Crowne & Marlowe, 1960; Reynolds, 1982). Participants were presented these 5 measures, with each on a single web page (DIT dilemmas on three separate web pages). With the exception to the demographics form, pages were generated in random order to control for response set effects.

The Defining Issues Test

Derived from Kohlberg's theory of moral development, the Defining Issues Test (DIT; Rest, 1979) is an objective paper-and-pencil questionnaire comprised of six dilemmas (three political and three moral dilemmas) that, unlike the Moral Judgment Interview (MJI), which is an interview based assessment, can be administered to groups and computer-scored (Rest, 1994). For each dilemma, there is a series of twelve arguments from which the individual taking the assessment can choose to "solve the conflict" (Gielen & Lei, 1991, p. 71). The forced answer solutions represent the various stages of moral development and measure specifically the individual's level of moral reasoning. The respondent is asked to rate the relative importance of the items based on a 5-point scale (*from no importance to great importance*), then the respondent is asked to rank which of the 12 arguments is most important, second important, and so on (Rest, 1990).

This objective measure provides scores for moral stages: 2, 3, 4, 5A, 5B, and 6. There are no stage one items on the DIT and principled reasoning, or the P index (P%), is represented by the combined ranks given to those items reflecting stage 5A, 5B, and 6 (Foster & Sprinthall,

1992; Rest, 1994). The P%-score ranges from 0 to 95, with high numbers indicating high moral judgment development; and is typically reported most in the research literature as the indicator of moral maturity (Gielen & Lei, 1991; Rest et al., 1997; Thoma, Rest, & Davison, 1991). Included in the DIT are validity and consistency checks. M-score items are used to ensure the participants understand the measure. The instrument also incorporates checks that compare the participants' ratings and rankings to ensure their overall congruence and consistency (Rest, 1994). According to the author, researchers can anticipate 5% to 15% of the sample being excluded once participants' M-scores and the consistency check protocols are considered (Rest, 1990).

The DIT short version, which is composed of three of the six dilemmas (see Appendix B), was given to participants in lieu of the long form as an attempt to reduce the likelihood of reactive testing effects. Rest (1990) contended that the short form of the DIT in effect has the same basic properties as the original long form of the measure. The DIT short form internal consistency reliability estimates were found to be .76 with Cronbach's alpha reliability falling in the upper .70s/low .80s across studies. (Rest, Narvaez, Bebeau, & Thoma, 1999; Rest, Thoma, Moon & Getz, 1986). Test-retest reliability was determined to be .77 (Rest, 1990).

Though the DIT is not a theoretical or empirical replacement of the MJJI, there is support for construct and convergent validity as there is significant positive correlation between the two measures of moral judgment (Gielen & Lei, 1991). The DIT was also shown to correlate with the Comprehension of Moral Concepts test in the .6 to .7 range (Rest, 1994). Additional support for construct validity of the DIT comes as a result of studies demonstrating the measure positive correlation to many prosocial behaviors and attitudes (Rest, 1994; Rest, et al., 1997). The DIT correlates at extremely low or non-significant levels with many personality trait measures and with measures of social desirability which supports the discriminant validity of the instrument (Rest, 1994).

The Multicultural Counseling Knowledge and Awareness Scale

During the past decade, there has been an increase in the interest of multicultural counseling competencies in research and program evaluation (Ponterotto, Gretchen, Utsey, Reiger, & Austin, 2002). As a result of this growing popularity, there have been a number of self-report multicultural counseling competence scales developed within the field of counseling (Constantine, Gloria, & Ladany, 2002; Kocarek, Talbot, Batka, & Anderson, 2001). Among these scales is the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), which is a revision made of earlier scales, the Multicultural Counseling Awareness Scale (MCAS; Ponterotto, Sanchez, & Magids cited in Ponterotto et al., 2002) and the MCAS-B (Constantine, et al., 2002). Like the other self-report measures of multicultural counseling competencies, the MCKAS was developed based on the conceptual framework of Multicultural Counseling Competencies outlined by Sue, et al. (1992).

The MCKAS is a two-factor, 32-item self-report assessment of an individual's perceived multicultural counseling knowledge and awareness (Ponterotto et al., 2002). It is comprised of two subscales, 20 Knowledge items and 12 Awareness items, which came from the original 45-item MCAS. Of the 12 items in the Awareness Scale, ten ($n = 10$) are reverse-worded (i.e., low score indicates high awareness) and need to be reverse-scored prior to any data analysis. After reverse-scoring, the total score range for the Awareness Scale ranges from 12 to 84 (or 1 to 7 for mean score) with higher scores indicating higher awareness of multicultural counseling issues. The score range for the Knowledge scale ranges from 20 to 140 using aggregate score, or 1 – 7 using a mean score. The MCKAS yields two scores that are mildly correlated ($r = 0.36$), supporting the explanation of separate subscales (Ponterotto & Potere, 2003).

Coefficient alpha reliability for the full scale scores as well as for the Knowledge subscale and the Awareness subscale were determined to be .85 (Ponterotto, et al., 2002).

Because the MCKAS is still in the early phases of research and testing, test-retest reliability coefficients are not yet available. Test-retest for the MCAS, the predecessor to the MCKAS, was .70 for the Knowledge/Skills subscale and .73 for the Awareness subscale (Manese et al., 2001).

Also, as the “MCKAS is still in its early stages of psychometric development, initial studies examining its psychometric properties supported identical factor structure proposed for the MCAS-B. Thus, the MCKAS is reported to possess adequate construct validity” (Constantine et al., 2002, p. 335). In addition, Ponterotto et al. (2002) found support for construct validity in a confirmatory factor analysis procedure, which tested the goodness-of-fit indicators of the measure.

The Attitudes Toward Disabled Persons Scale-Form O

“The Attitudes Toward Disabled Persons scale (ATDP) was constructed ... in an attempt to provide an objective, reliable, and valid measure of attitudes towards persons with physical disabilities” (Yuker & Block, 1986, p. 1). Since the ATDP (Yuker, Block, & Young, 1966) was developed, it has been used in numerous studies regarding persons with a variety of different disabilities (e.g. people who have epilepsy; people who are blind; and people who are deaf) and is considered the most widely used measure of attitudes of rehabilitation professionals (Pederson & Carlson, 1981). The ATDP is comprised of three alternative paper-and-pencil questionnaires (Form-O – 20 items; Form-A – 30 items; and Form-B – 30 items) all of which are considered equivalent to the others and can be used interchangeably (Yuker & Block, 1986).

The items on the ATDP forms are expressed as statements. The scale then elicits the respondents to indicate to what extent they agree with or disagree with the statements (Berry & Jones, 1991; Yuker & Block, 1986). The responses are in the form of a Likert-type scale ranging from +3 (*I agree very much*) to -3 (*I disagree very much*). The respondent is forced to choose either a positive or a negative answer because there is no 0 indicator (Biordi & Oermann, 1993).

The highest possible score on Form A and Form B is 180 and the highest possible score on Form O is 120. Higher scores suggest more positive attitudes toward persons with disabilities (Antonak & Livneh, 1988; Chen, Lee, Yuen & Chan, 2002; Yuker et al., 1966). Due to the inherent chance of social desirability bias of respondents trying to respond positively to scales such as the ATDP, the authors seriously considered this threat to the instrument's validity during its development. As such, there have been a number of studies concerning the influence of social desirability to the ATDP (Antonak & Livneh, 1988; Yuker et al., 1986). The authors determined from these studies that the data indicating that the ATDP scores were indeed slightly influenced by social desirability; however, the influence was not great enough to threaten the measure's validity.

The ATDP- Form O which consists of only 20 items (see Appendix B) was used in this study, like in the case of the DIT Short Form, as an attempt to reduce the likelihood of reactive testing effects. Yuker and Block (1986) contended that this shorter form is comparable to the other two forms. Correspondingly, the coefficient alpha reliability for each scale is in the upper .70s/low .80s. Test-retest is about the same (Biordi & Oermann, 1993; Yuker & Block, 1986). Test-retest reliability for Form O was found to be .83 and split-half reliability was .80.

The authors further indicated that there was clear indication of convergent validity of the ATDP. According to Yuker and Block, there were over 50 correlations of the ATDP forms (O, A, and B) and other scales measuring attitudes toward persons with disabilities at the time they put their 1986 monograph together. The correlations with these other scales ranged from .54 to .80 (median scores given). Findings were comparable between respondents who had disabilities and respondents who did not have disabilities. Yuker and Block illustrated a number of studies in their manual regarding correlations between the ATDP and the study of personality

characteristics. They determined that personality characteristics bared extremely low or non-significant correlations to the ATDP scale, thus supporting ATDP's discriminant validity.

Since the development of the ATDP forms, there have been a number of changes made in the social sciences literature regarding the use of the words '*disabled*' or '*handicapped*'. For instance, even the publishers of the most recent edition of the *Publication Manual for the American Psychological Association* (2001) provided guidelines for using unbiased language. These guidelines state that "preferred expressions avoid the implication that the person as a whole is disabled" (p. 76). As such, some of the language in the statement items of the ATDP Form-O was changed for use in this study. Such as, "Most disabled people worry a great deal" was changed to "Most people who have disabilities worry a great deal." Though modifying the scales by adding or subtracting items was discouraged, modifying the language was considered to be acceptable (Yuker & Block, 1986).

Marlowe-Crowne Social Desirability Scale-Short version

Although there are a number of instruments available that measure social desirability response (i.e., Crowne & Marlowe, 1960; Edwards, 1970; Messick, 1962), the Marlowe-Crowne Social Desirability Scale (MC) is by far the most popular and applied instrument (Barger, 2002; Crino, Svoboda, Rubinfeld, & White, 1983; Reynolds, 1982). Social desirability according to the Crowe and Marlowe (1960) was defined as an individual's need to "... obtain approval by responding in a culturally appropriate and acceptable manner" (p. 354). The scale, like the others being used in this study, is a paper-and-pencil forced-choice questionnaire. It contains 33 true-false items relating to typical behaviors (Beretvas, Meyers, & Leite, 2002). Higher scores represent higher numbers of socially desirable reactions endorsed. The original psychometrics for the MC scale were normed on 39 undergraduate college students (internal consistency = .88 and test-retest of 31 students $r = .89$) (Barger, 2002; Crowne & Marlowe, 1960). In a later study

investigating the Marlowe-Crowne Social Desirability Scale, the coefficient alpha was reported to range from .70 to .73 and the test-retest reliability was reported as .86 (Crino, et al., 1983).

In part due to the popularity of the MC scale, there have been a number of short forms derived from it (e.g., Reynolds, 1982; Silverstein, 1983; Strahan & Gerbasi, 1972). From his analysis, Reynolds (1982) developed three short forms to the MC scale (11-items, 12-items, and 13-items). Based on the results of this analysis, the 13-item form (M-C Form C; $r_{KR-20} = .76$) was “recommended as a viable short form for use in the assessment of social desirability tendencies” (p. 124). Correlations between the short forms were made with the MC standard form and the Edwards Social Desirability Scale. As such, concurrent validity for the 13-item form was $r = .93$ with the standard MC scale. Correlations with the Edwards scale were low, but this was consistent with correlations found previously (Crowne & Marlowe, 1960; Reynolds, 1982). It has been shown to compare favorably with other short form versions of the MC scale, but has one-third less questions (Reynolds, 1982). Further analyses of the short forms have revealed mixed reviews (Barger, 2002; Fabroni & Cooper, 1989; Silverstein, 1983; Zook & Sipps, 1985). Despite these diverse positions, the 13-item version of the Marlowe-Crowne Social Desirability Scale was used in this study. Because identified sociability is a significant characteristic of a multiculturally competent counselor (Pederson, 1987, as cited in Sadowsky, et al., 1998), assessing the impact of social desirability on the self-report measures in this study was an essential consideration.

Data Collection Procedures

Permission was granted by The College of William and Mary’s Institutional Review Board regarding the protection of human subjects on March 22, 2004. Permission from the ACA was also obtained prior to obtaining the sample list from the organization. Once permission was granted, a post card introducing the study was sent to 500 ACA members on April 10, 2004. This

study incorporated the use of conducting research surveys via the worldwide web. The initial mass e-mailing was sent out on April 18, 2004. In the introduction e-mail, each participant was given a code to enter for access to the web site. The purpose of this identification code was to maintain confidentiality of the participants, for tracking purposes, to keep participants' measures together, and for delivery of gifts of appreciation. The web based survey research consisted of the following:

1. an e-mail introducing myself, the study, human subjects approval, the amount of time the assessments should take, reward incentives, and the intended use of the research investigation,
2. a consent form,
3. demographic form,
4. the Defining Issues Test (DIT) Short Form,
5. the Multicultural Counseling Knowledge and Awareness Scale (MCKAS),
6. the Attitudes Toward Disabled Persons Scale (ATDP) Form O, and
7. the Marlowe-Crowne Social Desirability Scale (MC) Form C.

Pencil-and-paper copies were available to participants upon their request. Five such copies were distributed, and included:

1. a letter introducing myself, the study, human subjects approval, the amount of time the assessments should take, reward incentives, and the intended use of the research investigation,
2. two copies of the consent form,
3. a demographic form,
4. the Defining Issues Test (DIT) Short Form,
5. the Multicultural Counseling Knowledge and Awareness Scale (MCKAS),

6. the Attitudes Toward Disabled Persons Scale (ATDP) Form O,
7. the Marlowe-Crowne Social Desirability Scale (MC) Form C, and
8. a self-addressed stamped envelope/ or the option to fax complete forms.

As an incentive to participate, all volunteers who completed the survey were entered into a drawing for one of three (3) prizes: one \$100 gift certificate to Barnes and Noble Bookstores and two \$50 gift certificates to Barnes and Noble Bookstores.

Data Analysis

As stated previously, this study applied multiple regression analyses to determine the relationships among moral developmental level, as measured by the DIT (Rest, 1990), counselors' perceived multicultural knowledge and awareness, as measured by the MCKAS (Ponterotto et al., 2002), and their perceived attitudes towards individuals how have disabilities, as measured by the ATDP – Form O (Yuker, 1986). To rule out other conceivable explanations of variance (Licht, 1995), the following control variables: level of education; level of experience; race (white vs. non-white); gender; whether the counselor had formal multicultural training; whether the counselor had formal disabilities issues/studies training; and social desirability bias, as measured by the Form C (Reynolds, 1982), a shortened version of the Marlowe-Crowne Social Desirability Scale (MC; Crowne & Marlowe, 1960), were statistically controlled for in the study.

Control Variables

Though gender has been determined to be a non-significant predictor of moral judgment, there has been slight gender differences found on the DIT ($d = .21$; Rest et al., 1986). Therefore, to mitigate possible confounding effects, gender was considered a control variable. Education level was also used as a control variable due to the significance of the variable found in moral reasoning literature (Rest, 1994; Rest, et al., 1999). In addition, the level of multicultural training

and race have both been shown to significantly relate to multicultural counseling competence scores (Holcomb-McCoy & Myers, 1999; Kocarek et al., 2001; Ponterotto, et al., 2000; Pope-Davis & Dings, 1995; Sadowsky et al., 1998; Vinson & Neimeyer, 2003), and social desirability has been cited as an area of concern for self-report measures of multicultural counseling competencies (Constantine & Ladany, 2001; Pope-Davis & Dins, 1994).

Ethical Considerations

Trochim (1999) identified voluntary participation, informed consent, risk of harm, and confidentiality and anonymity as the ethical considerations in contemporary research. In addition to fulfilling these ethical requirements and those of the School of Education's Human Subjects Research Committee and the College's Institutional Review Board, this research investigation also adhered to the ethical standards for research in the Code of Ethics and Standards of Practice of the American Counseling Association (ACA) pertaining to research and publication. This investigation was submitted to and approved by the human subjects committee at The College of William and Mary.

All participants took part on a volunteer basis and were not be coerced. "Participation in research is typically voluntary and without penalty for refusal to participate" (ACA, 1997, p. 10). Participants in this investigation were also notified of what will occur in the research study and the intended use of the research (Gall, Borg & Gall, 1996). This investigation abided by the following ACA code for informed consent:

In obtaining informed consent for research, counselors use language that is understandable to research participants and that ... accurately explains the purpose and procedures to be followed ... describes the attendant discomforts and risks ... offers to answer any inquiries concerning the procedures ... describes any limitations on

confidentiality; and ...instructs the subjects are free to withdraw their consent and to discontinue participation in the project at any time. (ACA, 1997, p. 10)

Throughout this investigation all reasonable precautions were taken to ensure the safety of the participants. At no time was deception a part of the study in accordance with the Code of Ethics and Standards of Practice of the ACA, which states "... counselors who conduct research with human subjects are responsible for the subjects' welfare ... and take reasonable precautions to avoid causing injurious psychological, physical, or social effects of their subjects" (p. 10). Participants were informed of all expectations throughout the research process, and all results will be available to participants at the end of the investigation.

Finally, participants were told prior to taking part in research who would have access to the data and should, therefore, expect their information to remain confidential (Gall et al., 1996). Following the Code of Ethics and Standards of Practice of the American Counseling Association (ACA) ensures "information obtained about research participants during the course of an investigation is confidential" (p. 10). All assessments, forms were coded to keep the survey packets together and to ensure confidentiality of the data.

CHAPTER FOUR

Analysis of the Data

Introduction

This chapter presents the study's results in two sections: descriptive statistics regarding the measures used in this study and data analyses for the research hypotheses. For all statistical tests, an alpha level of .05 was used, unless otherwise specified.

*Descriptive Statistics**The Defining Issues Test (DIT)*

Participants' moral judgment scores were collected from the Defining Issues Test (DIT; Rest, 1986) short version P-scores. Of the 191 participants, there were 70 (36.65%) who were excluded from statistical analysis testing the hypotheses including moral judgment/moral development. This number exceeded the expected 5% to 15% as suggested in the DIT manual (Rest, 1990). These participants' score were deemed unusable after calculating participants' M (lofty or meaningless items) scores and all consistency check protocols (rank-and-ratings consistencies), included in the DIT scoring procedures. Thus, 121 participants produced useable protocols for all instruments. Otherwise, there was no significant differences between the two groups ($N = 191$ and $N = 121$; see Table 4.3). DIT P-scores may range from .00 to .95 with the higher P-score indicating higher moral judgment development (Rest, 1994). Rest (1990) reported that the average P% for a reference sample of 1080 was 34.77 ($SD = 16.67$). Generally, scores for senior high school respondents are in the 30's ($M = 31.03$, $SD = 13.90$), college respondents' scores are in the 40's ($M = 43.19$, $SD = 14.32$), graduate students' scores are in the 50's ($M = 44.85$, $SD = 15.06$), and scores of adults in general are in the 40's (Rest, 1990). The P-score measures for participants' in this investigation ranged from 6.67 to 83.33 ($M = 43.58$, $SD = 18.07$). When broken down by gender, males' scores ranged from 10 to 73.33 ($M = 37.31$, $SD =$

18.09) and females' scores ranged from 6.67 to 83.33 ($M = 45.32$, $SD = 17.88$, see Table 4.3 for participants' DIT scores according to gender and race). Score frequencies are shown in Appendix D Table D.1.

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS)

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto & Potere, 2003) was used to measure the participants' perceived level of multicultural knowledge and awareness. Because the two constructs were considered moderately independent from each other, the authors suggested that they be analyzed separately (Ponterotto & Potere, 2003).

Therefore, the MCKAS descriptive statistics were divided into two parts: Knowledge and Awareness as two separate constructs. Because analysis of the MCKAS was used in a multiple regression with the DIT and in a regression analysis not including the DIT, Knowledge and Awareness descriptive statistics are given for both $N = 121$ and $N = 191$. The Knowledge scale includes 20 items and the scale mean scores ranges from 20 to 140 (mean scores 1 to 7) with higher scores indicating higher perceived knowledge of multicultural counseling issues. The Awareness scale includes 12 items with scores ranging from 12 to 84 (mean scores 1 to 7) with higher scores indicating higher awareness of multicultural counseling issues (see Table 4.1 and Table 4.2 for MCKAS subscales mean scores).

The Knowledge scale ($N = 121$) mean scores for participants' of the small group ranged from 2.1 to 7 ($M = 5.22$, $SD = 0.84$, $Mdn = 5.25$, $Mode = 5.95$). The mean score for males in this group was 5.14 ($SD = .79$) and for females the mean score was 5.24 ($SD = .86$, see Table 4.3 for Participants' MCKAS Knowledge Scale mean scores according to gender and race). The Knowledge scale ($N = 191$) mean scores for the larger group participants' ranged from sum 2.1 to 7 ($M = 5.24$, $SD = 0.82$, $Mdn = 5.25$, $Mode = 5.2$). The mean score for males in this grouping was 5.12 ($SD = .86$) and for females the mean score was 5.28 ($SD = .81$, see Table 4.3 for

participants' MCKAS Knowledge Scale scores according to gender and race). Score frequencies are shown in Appendix D Tables D.2 and D.3.

Table 4.1
MCKAS Knowledge Scale Mean Scores

Participants' Mean Scores		Normative Sample Mean Scores	
$N = 121$		$N = 196$	
	$M = 5.22$		$M = 4.96$
	$SD = 0.84$		$SD = 0.80$
$N = 191$			
	$M = 5.24$		
	$SD = 0.82$		

Note. Norming sample data (Ponterotto, Gretchen, Utsey, Reiger, & Austin, 2002).

The Awareness scale ($N = 121$) mean scores for participants' in the small group ranged from 3.92 to 7 ($M = 5.90$, $SD = 0.68$, $Mdn = 6.0$, Mode = 5.58 and 6.42). The mean score for males was 5.91 ($SD = .73$) and for females the mean score was 5.90 ($SD = .67$, see Table 4.3 for Participants' MCKAS Awareness Scale scores according to gender and race). The Awareness scale ($N = 191$) mean scores for participants' in the larger group ranged from sum 3.33 to 7 ($M = 5.88$, $SD = 0.69$, $Mdn = 6.0$, Mode = 5.58 and 6.42) with mean scores for males ($M = 5.85$, $SD = .72$) and females ($M = 5.89$, $SD = .67$, see Table 4.3 for Participants' MCKAS Awareness Scale scores according to gender and race). The variance of the Awareness scale scores in this study appeared to be restricted in comparison to the norming sample and may have a negatively affected the strength of any correlation existing between the variables. Score frequencies are shown in Appendix D Tables D.4 and D.5.

Table 4.2
MCKAS Awareness Scale Mean Scores

Participants' Mean Scores		Normative Sample Mean Scores	
$N = 121$		$N = 196$	
	$M = 5.90$		$M = 5.06$
	$SD = 0.68$		$SD = 1.14$
$N = 191$			
	$M = 5.88$		
	$SD = 0.69$		

Note. Norming sample data (Ponterotto, Gretchen, Utsey, Reiger, & Austin, 2002).

The Attitudes Towards Disabled Persons (ATDP)

The Attitudes Towards Disabled Persons Scale (ATDP; Yuker & Block, 1986) was used to measure the participants' perceived attitudes towards people who have disabilities. Though there are three forms of the ATDP scale, this study used Form O because of its length and because the authors suggested that it takes less time to complete (Yuker & Block, 1986). Total scores can range from -60 to +60 on Form O. Once all scoring protocol is completed (i.e., reversing sign on 5 items and reversing the sign on the sum), a constant of 60 is added to the score on Form O to result in the theoretical range of scores 0 to 120. High scores relative to the group reflect more positive and accepting attitudes. Whereas, scores lower than the relative group reflect more negative or less accepting attitudes toward people with disabilities (Yuker & Block, 1986). A summary of normative data of the 38 studies using the ATDP Form O indicated that Median scores for combined male and female respondents was 79.7, with the average ranges of 52 to 90.4 (Yuker & Block, 1986). The ATDP scale ($N=121$) scores for participants' in the smaller group ranged from sum 61 to 120 ($M = 88.76$, $SD = 12.17$, $Mdn = 90$, $Mode = 85$). The mean score for males in this grouping was 84.65 ($SD = 9.35$) and for females the mean score was 89.70 ($SD = 12.59$, see Table 4.3 for participants' ATDP Scale scores according to gender and race). The ATDP scale ($N=191$) scores for the larger group participants' ranged from sum 50 to 120 ($M = 87.84$, $SD = 12.83$, $Mdn = 88$, $Mode = 87$) with mean score for males ($M = 85.14$, $SD = 11.20$) and for females ($M = 88.47$, $SD = 13.20$, see Table 4.3 for Participants' ATDP Scale scores according to gender and race). Score frequencies are shown in Appendix D Tables D.6 and D.7.

The Marlowe-Crowne Social Desirability Scale

The Marlowe-Crowne Social Desirability Scale Form C (Crowne & Marlowe, 1960; Reynolds, 1982) was used as a control variable to assess the participants' social desirability on

the other self-report measures used in this investigation. The Form C of the Marlowe-Crowne is comprised of 13 items from the original instrument (Item 3, 6, 10, 12, 13, 15, 16, 19, 21, 26, 28, 30, and 33). The scores can range from 0 (when no answers match) to 13 (with all answers matching). Higher scores indicate a higher need for approval (Robinson, Shaver, Wrightsman, 1991). The Marlowe-Crowne Form C scale ($N=121$) scores for participants' in the smaller group ranged from sum 0 to 13 ($M = 5.64$, $SD = 3.25$, $Mdn = 6$, Mode = 3). The mean score for males was 5.04 ($SD = 3.63$) and for females the mean score was 5.75 ($SD = 3.13$, see Table 4.3 for participants' Marlowe-Crowne Social Desirability Scale Form C Scores according to gender and race). The Marlowe-Crowne scale ($N=191$) scores for the large group participants' ranged from sum 0 to 13 ($M = 5.65$, $SD = 3.21$, $Mdn = 6$ Mode = 6). The mean score for males in this grouping was 5.64 ($SD = 3.43$) and for females the mean score was 5.61 ($SD = 3.17$, see Table 4.3 for participants' Marlowe-Crowne Social Desirability Scale Form C scores according to gender and race). Score frequencies are shown in Appendix D Tables D.8 and D.9.

Table 4.3
Participants' Mean Scores according to Race/Ethnicity and Gender

Scales	Male				Female			
	White		Non-White		White		Non-White	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
DIT <i>N</i> = 121 <i>N</i> = 191	37.31 -----	18.09 -----	43.30 -----	----- -----	46.0 -----	18.59 -----	38.93 -----	15.59 -----
MCKAS Knowledge <i>N</i> = 121 <i>N</i> = 191	5.13 5.12	0.80 0.86	5.20 5.05	----- 0.84	5.22 5.25	0.80 0.77	5.37 5.47	1.31 1.02
MCKAS Awareness <i>N</i> = 121 <i>N</i> = 191	5.90 5.85	0.74 0.72	6.33 5.83	----- 1.09	5.90 5.92	0.68 0.69	5.88 5.78	0.61 0.55
ATDP <i>N</i> = 121 <i>N</i> = 191	84.65 85.14	9.35 11.20	107.00 95.33	----- 12.58	90.18 88.87	12.84 13.62	85.70 86.18	9.86 10.50
Marlowe-Crowne <i>N</i> = 121 <i>N</i> = 191	5.04 5.64	3.63 3.43	10.00 7.67	----- 2.08	5.57 5.41	3.01 3.12	7.30 6.73	3.83 3.25
TOTAL <i>N</i> = 121 <i>N</i> = 191	<i>N</i> = 26 <i>N</i> = 42		<i>N</i> = 1 <i>N</i> = 3		<i>N</i> = 84 <i>N</i> = 124		<i>N</i> = 10 <i>N</i> = 22	

Note. ^a Due to low survey returns from participants of minority race/ethnicity groups, Non-White category is used in future analysis and includes African-American/Black, Hispanic/Latino(a), American Indian/ Alaskan, Asian/Pacific Islander, and Multiracial.

^b Standard Deviation (*SD*) for Non-White males could not be calculated for *N* = 121. There is only one participant in this category.

Data Analysis of the Research Hypotheses

In this investigation, three hypotheses were tested based on data collected from the Defining Issues Test (DIT), the Multicultural Knowledge and Awareness Scale, and the Attitudes Towards Disabled Persons Scale. Relationships among the participants' scores on these measures were considered to test the following hypotheses.

Hypothesis One

Using a multiple regression analysis, counselors' scores on the DIT short form will account for more variance in the prediction of scores on the MCKAS Knowledge Scale than any of the remaining predictor variables entered.

A multiple regression with a simultaneous method of entry was the statistical analysis used to test hypothesis one. Control variables in this analysis were gender, race, education level, years of experience, multicultural counseling training, and scores from the Marlowe-Crowne Social Desirability Scale. Using the enter method, no significant model emerged (constant, $F(7,113) = 1.459, p = .162$; P-scores, $F(8,112) = 1.554, p = .171$). Adjusted R square = .026 for Model 1 (constant predictor variables) and Adjusted R square = .036 for Model 2 (P-scores). In Model 1, the small effect size indicates that only 2.6 % of the variance could be accounted for from the model. The small effect size in Model 2 indicates that only 3.6% of the variance could be accounted for by the model with P-scores included. The only significant variable in either model was Marlowe-Crowne scores (Model 1: Beta = .209; $p = .028$ and Model 2: Beta = .215; $p = .023$).

No significant positive correlation was found between P scores on the DIT short version and MCKAS Knowledge scale scores. Thus, the first hypothesis was not confirmed by the findings.

Hypothesis Two

Using a multiple regression analysis, counselors' scores on the DIT short form will account for more variance in the prediction of scores on the MCKAS Awareness Scale than any of the remaining predictor variables entered.

Again, a simultaneous method of entry was the statistical analysis used to test hypothesis two and the control variables in this analysis were also gender, race, education level, years of experience, multicultural counseling training, and scores from the Marlowe-Crowne Social Desirability Scale. Using this method of multiple regression, a significant model emerged (constant, $F(7,113) = 1.483, p = .180$; P-scores, $F(8,112) = 3.483, p = .001$). Adjusted R square = .027 for Model 1 (constant predictor variables) and Adjusted R square = .142 for Model 2 (P-

scores). A significant effect size was obtained in Model 2 (Adjusted R square = .142, p = .001), which shows practical significance of results of this test. Significant variables are shown in Table 4.4.

Table 4.4
Significant Variables for Hypothesis One (Awareness)

	B	$SE\ B$	β	t	p
Model 1					
Marlowe-Crowne	-.654	.236	-.260	-2.771	.007
Model 2					
Marlowe-Crowne	-.617	.222	-.245	-2.781	.006
P-scores	.161	.040	.357	4.012	.000

Note. N = 121. (Seventy of the DIT protocols failed to pass the five reliability checks.)

There was a positive and significant relationship found between principled reasoning scores (P scores) on the DIT short form and scores on the Awareness scale of the MCKAS thus supporting the hypothesis. Furthermore, the DIT P-scores and the scores of the Awareness scale of the MCKAS had 14% of their variance in common. This hypothesis was accepted.

Hypothesis Three

Using a multiple regression analysis, counselors' scores on the DIT will account for more variance in the prediction of scores on the ATDP Form O than any of the remaining predictor variables entered.

Entering the variables in a simultaneous method, a multiple regression was the statistical analysis used to test hypothesis three. The criterion variable for this hypothesis was the ATDP-O scale scores and the control variables were gender, race, education level, years of experience, disabilities studies class, and scores from the Marlowe-Crowne Social Desirability Scale. Using the enter method, no significant model emerged (constant, $F(7,113) = 1.537$, p = .162; P-scores, $F(8,112) = 1.485$, p = .171). Adjusted R square = .030 for Model 1 (constant predictor variables) and Adjusted R square = .031 for Model 2 (P-scores). In Model 1, the small effect size indicates

that only 3.0 % of the variance could be accounted for from the model. The small effect size in Model 2 indicates that only 3.1% of the variance was accounted for by the model with P-scores included. The only significant variable found in model 2 was gender (Beta = .209; $p = .028$).

Thus, this hypothesis was rejected and the null was accepted.

Hypothesis Four

Using a multiple regression analysis, counselors' scores on the Knowledge scale of the MCKAS will account for more variance in the prediction of scores on the ATDP Form O than any of the remaining predictor variables entered.

Hypothesis Five

Using a multiple regression analysis, counselors' scores on the Awareness scale of the MCKAS will account for more variance in the prediction of scores on the ATDP Form O than any of the remaining predictor variables entered.

A stepwise method linear multiple regression was the statistical analysis conducted to test hypotheses four and five. Predictor variables, multicultural counseling knowledge and awareness, were entered into the stepwise method. The criterion variable for this hypothesis was the ATDP-O scale scores and the control variables using the enter method were gender, race, education level, experience, multicultural counseling training, disabilities studies class, and scores from the Marlowe-Crowne Social Desirability Scale. Using the stepwise method with the multicultural knowledge and awareness, a significant model emerged (constant, $F(8,182) = .769$, $p = .631$; Awareness scores, $F(9,181) = 2.388$, $p = .014$). Adjusted R square = -.010 for Model 1 (constant predictor variables) and Adjusted R square = .062 for Model 2 (Awareness scores). A significant effect size was obtained in Model 2, which showed practical significance of results of this test. Significant variables are shown in Table 4.5.

Table 4.5
Significant Variable for Hypothesis Three (Stepwise method)

	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
Model 2					
Awareness scores	.435	.113	.280	3.856	.000

Note. N = 191.

In a second analysis in which Knowledge then Awareness was forced into a linear multiple regression, perceive multicultural counseling knowledge was found to be significant with the participants' attitudes toward people with disabilities as measured by the ATDP-O when perceived multicultural counseling awareness was not considered. However, the Knowledge variable was not found to be significant when Awareness was added to the model (see Table 4.6).

Table 4.6
Significant Variable for Hypothesis Three (Enter method)

	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
Model 2					
Knowledge scores	.170	.058	.218	2.936	.004
Model 3					
Knowledge scores	.102	.061	.131	1.667	.097
Awareness scores	.360	.121	.231	2.967	.003

Note. N = 191.

When forced first, the perceived multicultural counseling knowledge emerged as a significant predictor to participants' attitudes towards people with disabilities; however, there was no significant relationship between attitudes toward people with disabilities and perceived multicultural counseling knowledge when the stepwise method was used. The Awareness scale scores subsumed the variance accounted for by the knowledge scale scores. Thus, hypothesis four was rejected and the null was accepted.

Using the stepwise linear multiple regression, there is a positive and significant relationship between attitudes toward people with disabilities, as measured by the ATDP-O, and perceived multicultural counseling awareness, as measured by the Awareness Scale of the MCKAS. In addition, 6 % of the variance is accounted for by the awareness scale of the MCKAS. Hypothesis five is therefore accepted.

Conclusion

This chapter presented results of an exploration of relationships among counselors' moral development, perceived multicultural knowledge and awareness competencies, and attitudes toward people who have disabilities. The next chapter examines the meaningfulness of the statistically significant results found for two of the five hypotheses and discusses important implications of the research as well as the study's limitations.

CHAPTER FIVE

Discussion, Conclusions, and Implications

Introduction

The results of this study contribute in several ways to the current body of literature on moral development, multicultural counseling competencies, and counselors' attitudes towards people with disabilities. In part, the findings of this study are consistent with and support the current related literature. There were also competing results found, which may offer new ways of approaching the constructs considered in this investigation.

This chapter includes a brief overview of the study and its results. In addition, this chapter will discuss limitations of the study, contributions and implications of the findings, as well as recommendations for future research.

Overview of the Study

Review of current literature highlighted the concern that counselor education programs are not normally providing curriculum or discussion regarding people with disabilities; and, in the few instances that disability has been discussed, it is often viewed from a deficit-treatment perspective (Bluestone, Stokes, & Kuba, 1996; Gilson & DePoy, 2002; Milsom, 2002; Olkin, 2002). Yet, there is still the expectation that the goal of counselor education programs should be to prepare and assist students in becoming competent service providers for their culturally diverse clients, including clients of other areas of human diversity such as disabilities (Lofaro, 1982; Strohmer, Biggs, Haase, & Purcell, 1983).

The literature review also demonstrated that counselors who process their experiences, at the higher levels of cognitive development can function more effectively in variety of counseling tasks, including problem-solving abilities, empathy, ability to recognize individual differences, valuing cultural diversity, and being aware and knowledgeable of self (Sprinthall et al., 2000).

Though there have been recent studies considering cognitive development and the multicultural competencies of counselors and multicultural training, this research is limited (i.e., Grothaus, 2004; Milliken, 2004; Taylor, 2004). In addition, there was no literature found that focused on the multicultural competencies of counselors and their attitudes towards people who have disabilities. Therefore, the basis for this study came about as an attempt to fill the gap of the limited research concerning the relationships among cognitive development, multicultural competencies, and attitudes towards people with disabilities of counselors.

This study surveyed 985 randomly selected members of American Counseling Association (ACA). Of the 985 initial e-mail requests sent to members, 231 e-mails were returned as undeliverable resulting in 754 ACA members who were solicited to volunteer to complete the web based survey. Of this group, $N = 191$ participants submitted completed surveys (25.33% response rate). The survey included the Defining Issues Test (DIT) short version, the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), the Attitudes Towards Disabled Persons Scale (ATDP-O), the Marlowe-Crowne Social Desirability Scale (Form C), and a researcher designed Demographic Form. Multiple regression analyses of data collected were used to test the study's five directional hypotheses.

Hypothesis One

Using a multiple regression analysis, counselors' scores on the DIT short form will account for more variance in the prediction of scores on the MCKAS Knowledge Scale than any of the remaining predictor variables entered.

Hypothesis Two

Using a multiple regression analysis, counselors' scores on the DIT short form will account for more variance in the prediction of scores on the MCKAS Awareness Scale than any of the remaining predictor variables entered.

As the Knowledge and the Awareness scales in the MCKAS are considered to be independent, a separate regression analysis was run on each. A multiple regression with simultaneous entry of the variables was the statistical analysis used to test hypotheses one and two. Using multiple regression analysis, no significant model emerged when testing hypothesis one (constant, $F(7,113) = 1.459, p = .162$; P-scores, $F(8,112) = 1.554, p = .171$). Social desirability as measured by scores of Marlowe-Crowne, however, was found to be a significant variable in both models of hypothesis one (Beta = .209; $p = .028$ and Model 2: Beta = .215; $p = .023$). Hypothesis one was rejected and the null was accepted.

Using the same multiple regression method, a significant positive correlation at the .05 alpha level was found between principled reasoning scores (P scores) on the DIT short form and scores on the Awareness scale of the MCKAS (Adjusted R square = .142, $p = .001$) thus supporting hypothesis two. Additionally, moral judgment score and multicultural awareness competency scores had a 14.2 % shared variance and showed practical significance of results of this test. As when testing hypothesis one, the Marlowe-Crowne scores were found to be significantly related to the MCKAS Awareness scores when hypothesis two was explored (Model 1: Beta = -.260; $p = .007$ and Model 2: Beta = -.245; $p = .006$).

Because social desirability is a potential limitation associated with instruments measuring multicultural counseling competencies (Constantine & Ladany, 2001; Pope-Davis & Dings, 1995), the Marlowe-Crowne Social Desirability Scale was used to offset potential social desirability in responses. To date, results regarding social desirability of the multicultural counseling competency scales have been mixed (Ponterotto & Alexander, 1996; Sadowsky et al., 1994; Sadowsky et al., 1998). Social desirability was found to be significant when considering multicultural counseling competencies (knowledge and awareness) with moral development in the present study. Consequently, significance between these variables may indicate a limitation

with respect to participants' desire to answer in a socially accepted way which may have negatively impacted this study's data.

Hypothesis Three

Using a multiple regression analysis, counselors' scores on the DIT will account for more variance in the prediction of scores on the ATDP Form O than any of the remaining predictor variables entered.

A linear multiple regression with a simultaneous method of entry was the statistical analysis used to test hypothesis three. Using the enter method, no significant model emerged (constant, $F(7,113) = 1.537, p = .162$; P-scores, $F(8,112) = 1.485, p = .171$). The only significant variable found in model 2 was gender (Beta = .209; $p = .028$). This finding corroborates previous research that gender significantly influenced positive attitudes towards people with disabilities (Hunt & Hunt, 2000; Yucker, 1994). This hypothesis was rejected and the null was accepted.

Hypothesis Four

Using a multiple regression analysis, counselors' scores on the Knowledge scale of the MCKAS will account for more variance in the prediction of scores on the ATDP Form O than any of the remaining predictor variables entered.

Hypothesis Five

Using a multiple regression analysis, counselors' scores on the Awareness scale of the MCKAS will account for more variance in the prediction of scores on the ATDP Form O than any of the remaining predictor variables entered.

A stepwise method linear multiple regression was the statistical analysis conducted to test hypothesis four and five. Predictor variables, multicultural counseling knowledge and awareness, were entered into the stepwise method. Using the stepwise method with the multicultural knowledge and awareness, a significant model emerged with Awareness (constant, $F(8,182) =$

.769, $p = .631$; Awareness scores, $F(9,181) = 2.388$, $p = .014$). Using the stepwise linear multiple regression, there was no positive relationship found between attitudes toward people with disabilities, as measured by the ATDP-O, and perceived multicultural counseling knowledge, as measured by the Knowledge Scale of the MCKAS. Hypothesis four was rejected and the null accepted. There was, however, a significant relationship found between attitudes toward people with disabilities and perceived multicultural counseling awareness thus hypothesis five was accepted.

Discussion

As the direction of the study was guided by three research questions, discussion of the study's results will be used to answer these questions:

1. What is the degree and direction of the relationship between counselors' moral developmental levels as measured by the DIT and their perceived multicultural counseling competencies as measured by the MCKAS?
2. What is the degree and direction of the relationship between counselors' moral developmental levels as measured by the DIT and their attitudes towards people with disabilities as measured by the ATDP- O?
3. What is the degree and direction of the relationship between counselors' attitudes towards people with disabilities as measured by the ATDP-O and their perceived multicultural counseling competencies as assessed by the MCKAS?

Moral Development and Multicultural Counseling Competencies

Though it has been determined that multicultural training seems to be linked to higher levels of counselors' perceived multicultural counseling competency (Ponterotto & Casas, 1987; Pope-Davis & Dings, 1995; Stewart et al., 1998; Vinson & Neimeyer, 2003) and that counselors who process their experiences at the higher levels of cognitive development are more capable of

taking on the perspectives or worldviews of their clients (Sprinthall et al., 2000), no studies prior to this one were found to have significant correlations between multicultural competencies and moral reasoning levels. Most investigations to date have been able to demonstrate trends, but not conclusive significant relationships between multicultural competencies and moral development (e.g., Grothaus, 2004; Milliken, 2004; Taylor, 1994). This exploration found a positive significant relationship between levels of counselors' moral reasoning and their perceived multicultural counseling awareness competency. The positive correlation coefficient between the scores from the DIT and the MCKAS knowledge scale, however, was not statistically significant ($p = .171, p < .05$).

In one investigation exploring multicultural experience, rather than training, patterns were found indicating that intercultural development and multicultural experience were related to intercultural sensitivity and that the depth of the participants' intercultural experiences was a significant indicator of the participants' moral development (Endicott, Bock, & Narvaez, 2003). Based on their findings, the authors recommended in order to promote growth more time should be spent to understand values and worldviews of those from other cultures, rather than simply providing topical information about the cultures. This may suggest that knowledge of cultural perspectives is certainly a necessary component for the intercultural sensitivity, but is not sufficient.

The findings from the present study indicating counselors' moral developmental level had a significant positive relationship with their multicultural counseling awareness, but not with multicultural counseling knowledge, may support the authors' supposition. Multicultural awareness is the understanding of one's own cultural socialization and accompanying biases and is necessary for acknowledging how beliefs, attitudes, and values, especially involving other people, have been shaped (Arredondo et al., 1996; Sue et al., 1992). This awareness also

encompasses an acceptance of others' worldviews (Arredondo et al., 1996; Sue et al., 1992). Therefore, having knowledge about the particular groups is important for working effectively and competently with them; but, the knowledge may be insufficient if the counselor does not have an awareness of their own culture and an awareness of how their cultural perspective shapes their perceptions of others' worldviews.

According to Arredondo et al. (1996), counselors who are multiculturally competent possess self-awareness and are able to continually engage in a process of challenging their own attitudes and beliefs, can identify social and cultural influences on their ability to process information, and are able to recognize limits to their multicultural competencies. Counselors who are perceived as being more multiculturally competent also convey trustworthiness and empathy (Fuertes & Brobst, 2002). Like these higher levels of multicultural counseling competencies, characteristics of higher levels of moral development have been shown to be associated with qualities considered positive for counselors such as displaying a greater propensity for adaptive behavior, conveying an enhanced empathic communication with a greater diversity of clients, exhibiting less bias and prejudice, and having a greater appreciation of cultural diversity (Chang, 1994; Foster & McAdams, 1998; Peace, 1995; Reiman & Thies-Sprinthall, 1993; Sprinthall, 1994; Thoma & Rest, 1986). There is empirical evidence that the Deliberate Psychological Education (DPE), as described in Chapter Two, contains the elements necessary to facilitate cognitive growth (Sprinthall & Thies-Sprinthall, 1983). Based on the results of this study, the DPE model may be a viable option for counselor education and other areas of professional counselor development (i.e., supervision and continuing education). Whereby promoting cognitive development may also support the higher levels of counseling processes related to multicultural counseling awareness competencies.

Moral Development and Attitudes towards People with Disabilities

In exploring the degree and direction of the relationship between counselors' moral developmental levels and their attitudes towards people with disabilities the present study found that there was no significant relationship. Given that the available literature examining the relationship between cognitive development of counselors and their attitudes toward people with disabilities is based on a different domain of cognitive development than the present study and focused specifically on rehabilitation counselors (Millington et al., 1996), makes it difficult to compare the findings. It should be noted, however, that a number of studies have shown a relationship between the various domains of cognitive development, including conceptual reasoning and moral development, and positive counselor qualities necessary to meet the needs of their clients (Foster & McAdams, 1998; Holloway & Wampold, 1986; Holloway & Wolleat, 1980; Richardson, Foster, & McAdams, 1998; Stoppard & Miller, 1985).

Even with this concept in mind, the results of the present study are inconsistent with the results of the previous study considering rehabilitation counselors' level of conceptual complexity with their attitudes towards people with disabilities. Whereas the present study found no relationships between the variables, Millington et al. (1996) found an inverse relationship between counselors' level of conceptual complexity and their attitudes towards people with disabilities (Millington et al., 1996). They determined the reason for this inverse relationship was because counselors who were more aware of the realistic differences between themselves and clients were less subject to biases and more capable of making sound judgment throughout the counseling process.

In another study, Strohmer, Biggs, Haas, and Purcell (1983) investigated the relationship between counselors' level of empathic responses, anxiety, and cognitive complexity. Empathy is an important factor when working with diverse populations. For example, counselors who are

not able to project appropriate empathetic responses to their clients who have disabilities often demonstrate sympathetic or patronizing interactions which ultimately get in the way of the counseling relationship (Lofaro, 1982). As was expected, the authors found a significant main effect for empathy with cognitive complexity. The researchers determined that students with higher levels of cognitive complexity are more empathetic and less likely to be biased when working with clients who have disabilities (Strohmer et al, 1983).

When considering the lack of relationship between the variables in the present study, there is always the chance that there is actually no relationship between them. However, based on the results of the other analyses in this study and previous research as well as the amount of error inherent in the instruments used for this study, it is also a possibility that other factors may have contributed to a Type II error of not finding significance where it actually may have existed.

Multicultural Counseling Competencies and Attitudes towards People with Disabilities

When considering the third research question exploring the degree and direction of the relationship between counselors' multicultural counseling competencies and their attitudes towards people with disabilities, the results indicated a statistically significant positive relationship between counselors' attitudes towards people with disabilities and their perceived multicultural counseling awareness competency. Multicultural knowledge competency was significant when entered first, before awareness, as a predictor variable and analyzed in an enter method multiple regression. It was not found to be a strong predictor, however, when analyzed in the stepwise regression analysis. Again, as with the relationship between moral development and multicultural counseling competencies, knowledge may be necessary but not sufficient for the most constructive or efficient counseling with clients from different cultural backgrounds and areas of human diversity.

Multicultural counseling once focused predominantly on race, ethnicity, and racial identity (Allison et al., 1994). Now, with an expanding perception of multiculturalism to include the intersections of cultural factors (e.g., disability, gender, and sexual orientation), there is a greater need to assist counselors in understanding how multicultural competencies enhance effective and appropriate multicultural counseling with a variety of clients (Fuentes & Brobst, 2002), including those who have disabilities. For counselors to truly possess multicultural competencies when working with clients from various minority groups, they are required to have higher order, more specific, and sophisticated counseling skills and awareness about self and others (Fuentes et al., 2001).

The correlation between the two constructs, attitudes towards people with disabilities and multicultural counseling competencies, found in the present examination would lend support to the idea that those who have higher levels of multicultural counseling awareness also have more positive attitudes towards people with disabilities. This present study's findings are not a contradiction of the available research since there are currently no studies examining the relationship between attitudes towards people with disabilities and multicultural counseling competencies. This study does, nevertheless, indicate that a rich multicultural counseling awareness may compensate for the lack of information and experience counselors receive regarding individuals who have disabilities, which has been a concern for researchers who focus on disabilities issues and counseling (i.e., Milsom, 2002; Olkin, 1999).

Bearing in mind the findings of the present study, it is important to consider how students are obtaining their multicultural counseling competencies for working with clients from various cultural and diverse backgrounds. An area of growing interest in multicultural counseling research considers this very topic. Experiential learning has been shown to raise knowledge, understanding, and sensitivity to multicultural issues (i.e., race, ethnicity, and racial identity)

(Arthur & Achenbach, 2002) and issues of human diversity, such as those who have disabilities (Miller & Cordova, 2000). As such, it has also been said that this teaching approach bridges the gap often found between theory and practice (Pope-Davis, Breaux, & Liu, 1997). Experiential learning is not meant to emulate a person's true experience; rather, it is to help students develop cultural empathy and awareness of self and of others' worldviews (Arthur & Achenbach, 2002). This type of learning seems to reflect social role-taking, which is one of the principle elements necessary to promote cognitive growth within the Deliberate Psychological Education (DPE; Sprinthall & Thies-Sprinthall, 1983). The DPE program's function and concepts were highlighted in Chapter Two.

Another consideration for these findings is that perhaps there are unidentified variables operating within both instruments. The instruments may in fact be tapping into another domain of cognitive development, cognitive complexity. Cognitive complexity is the information processing variable that allows people to distinguish and understand stimuli for making judgments (Harvey, Hunt, & Schroder, 1961). The theory describes conceptual complexity as a characteristic of an individual's ability to view situations and experiences in multidimensional ways (Holloway & Wampold, 1986). The conceptual developmental hierarchy begins with a concrete, dichotomous way of thinking, and extends to abstract, interdependent and autonomous ways of thinking. As one attains higher levels of conceptual complexity, her or his progression is toward the acquisition of more abstract functioning (Holloway & Wampold, 1986). This higher level of conceptual complexity has also been shown to be indicative of higher levels of empathy, more accurate clinical hypothesis formation, and being less subject to bias (Holloway & Wampold, 1986; Holloway & Wolleat, 1980; Millington et al., 1996). All of which are necessary skills for working competently with society's growing diversity of clients.

Limitations

When discussing the findings, it is equally important to also consider the limitations of the study. The findings in this study may be limited for several reasons. Foremost, this study used purposeful sampling which may signify the results are not necessarily generalizable to a larger population of counselors. Participation was voluntary. Using volunteers in research also limits generalizability because those who tend to volunteer may not necessarily represent the target population as a group (Gall, Borg, & Gall, 1996). In addition, there may have been those who were not motivated to complete the survey (e.g., because of the time frame for completing all of the instruments, not interested in the topic) but were enticed by the nominal award incentive. As a result, scores may be somewhat distorted. Having a small number of minority respondents was also a possible limitation of the study and likely reduced the validity of examining racial and/or ethnic differences in scores on the instruments. Limited demographic data were available for members of ACA. Therefore, it is not clear whether the participants in this study were indeed representative of the general population of counselors in the United States. Nonetheless, far fewer minority participants completed the survey.

Another potential limitation of this study is also inherent to relationship studies in general. That is, relationship studies cannot establish cause-and-effects relationships and are often criticized because the analysis breaks down complex ideas, behaviors, and abilities into simpler, or even simplistic, elements (Gall, et al., 1996). Using the shorter forms in this study may have also compromised the results. The survey measures and the demographic form are certainly subject to the limitations inherent in self-report measures. One such concern is that the participants may not have understood the directions on the measures, or the entire survey series. Utilizing the computer web based medium may have also contributed to this concern. Several participants responded via e-mail that they had difficulty understanding the DIT in this format.

This may have limited others' participation in the study. Additionally, the demographic survey was constructed by the researcher and tested on only a small pilot group. Preliminary findings were not obtained regarding reliability and validity of the survey.

A final limitation for this investigation may be the fact that survey data tend to reflect how people believe they would respond in certain situations, rather than how they actually behave when faced by such situations (Hunt & Hunt, 2000). The Marlowe-Crowne Social Desirability Scale was used to offset potential social desirability in responses. However, the social desirability variable was found to be significant when considering multicultural counseling competencies (knowledge and awareness) with moral development. Significance between these variables may indicate a limitation with respect to participants' desires to answer in a socially accepted way.

Contributions and Implications of Findings

Contributions

This study began by expressing the concern that counselors are entering the field with limited or no knowledge of the issues experienced by people who have disabilities. Counselors must be able to provide effective, sensitive, and competent services to their clients while respecting the competence of their clients. Yet, without the appropriate knowledge or experience in working with clients who have disabilities, the concern has been that counselors are not effectively meeting the needs of their clients. Previous literature revealed that counselors with more negative attitudes toward people with disabilities were less effective and often demonstrated sympathetic or patronizing interactions, which ultimately negatively impacted the helping relationship (Marshak & Seligman, 1993; Strohmer et al., 1983; Vash, 2001). Moral development, a domain of cognitive developmental theory, was introduced as the theoretical framework for this investigation, specifically examining the relationship of counselors' moral

developmental level and their attitudes towards people with disabilities and their perceived multicultural counseling competencies. Multicultural counseling competencies were considered since multiculturalism is said to include intersections with other areas of human diversity, not just race, ethnicity, and racial identity.

The present research study is the first to explore the relationships among moral development, multicultural counseling competencies, and attitudes towards people with disabilities. The outcome of this study presented interesting results. While moral reasoning development scores were positively related to multicultural counseling awareness scores and multicultural counseling awareness scores were correlated to participants' attitudes towards people with disabilities, moral development did not seem to be related to the participants' attitudes towards people with disabilities. Nonetheless, this study's primary contribution was that it showed support for cognitive developmentally based counselor education and professional development (i.e., trainings and supervision). Further support for an emphasis on cognitive and moral development in training programs and professional development can be found in this study's analysis of DIT P-scores. In this study, the average P score for all counselors was actually slightly higher than the norming sample's mean for college students but less than the mean for the college graduates in the norming sample.

The findings also suggested that counselors with higher levels of multicultural counseling competencies also have more positive attitudes towards people with disabilities. Attitudes are significant in determining how counselors view their multicultural clients and "it is not useful to acknowledge disability as a minority group with its own culture if one then devalues that culture" (Olkin, 1999, p. 91). With a greater awareness of one's own cultural biases and values, awareness of clients' worldviews and culturally appropriate counseling interventions, counselors have a greater potential to work effectively with clients from a variety of diverse backgrounds,

including clients with disabilities. This does not negate, though, the need for accurate and appropriate information about disabilities and the issues faced by people who have disabilities. While it may not be practical for all counselor education programs to add a class specifically addressing disability studies to their programs' curricula, the present study demonstrated that issues related to disability studies training and services within the field of counseling is an area worthy of further investigation.

Implications

Overall, information obtained from this study may be helpful in identifying training variables that could contribute to counselors' competencies when working with clients who have disabilities and their overall multicultural counseling competencies. Given the previously discussed limitations, however, the following implications are guarded.

As stressed in the literature, providing opportunities for participants to have exposure to and work with clients with disabilities (Chan et al., 2002; Hunt & Hunt, 2000; Lee & Rodda, 1994; Miller & Cordova, 2002; Strohmer, et al., 1983) and of various cultural backgrounds may be important for understanding and accepting clients' worldviews (Arthur & Achenbach, 2002; Holcomb-McCoy & Myers, 1999). Many individuals, however, report that they experience some level of discomfort in the presence of individuals with disabilities (Lofaro, 1982), or unprepared for the realities of working with diverse clients (Arthur & Achenbach, 2002; Milsom, 2002). So, these opportunities should also include an arena for counselors and counseling students to be able to voice their current understandings, including myths and misconceptions, about people who have disabilities (Hunt & Hunt, 2000), and other areas of cultural diversity (Hill, 2003). This can be done in the confines of an academic program or clinical supervision.

These factors such as taking on a new social role such as being exposed to different groups and cultures, the disequilibrium of being placed in a new situation or experience, and

having one's ideas, values, and biases challenged in a supportive open environment are all elements for promoting development found in the DPE discussed in Chapter Two. Counselor educators in academic programs and continuing education programs, as well as supervisors are encouraged to implement conditions that affect cognitive development in their programs or within the supervision process. This can be accomplished by implementing such strategies as, offering experiential learning, placing the counselors (or students) in new learning experiences, or encouraging diversity of viewpoints in the learning environment, while providing enough structure to ensure that the counselors (or students) feel safe to express the diverse points of view.

To further promote cognitive growth, the learning opportunity might include both challenging and supporting the individual to encourage reasoning slightly above their current level of functioning. This should be followed by a time to reflect on the new information and can be accomplished through journaling. These activities can take place in class discussions, small group exercises, and by introducing ethical dilemmas to discussion. This type of learning is different than and opposes the lecture format training that provides a "cookbook" for how to work with specific clients and fails to stimulate higher cognitive reasoning (Neukrug & McAuliffe, 1993). Given the results of this study indicated moral judgment was significantly related to multicultural counseling awareness, this way of learning is potentially a viable method for promoting multicultural counseling competency and cognitive growth.

Future Research

The results of this study point to many possibilities for future research on cognitive development, multicultural counseling competencies, and attitudes towards people with disabilities. A review of the literature revealed a lack of research regarding cognitive development and multicultural counseling competencies. There was also a lack of information

including disability within the conceptualization of multiculturalism. As previously discussed, this study was an attempt to examine the relationship among these constructs. Replication of this endeavor is suggested and a larger random sample should be used to ensure an adequate representation of counselors. The pairing of self-report instruments with behavioral observations to supplement and verify the validity of the measures' outcomes should also be considered in any follow-up investigation. In addition, a revision of the survey forms to translate better to a web based format may be warranted. Given several participants expressed concern specifically about the DIT in this format and the number of surveys that had to be excluded based on DIT protocols, the instrument may need to be revised to suit this new format. Of course, the paper-and-pencil method is certainly an acceptable alternative to web based surveys; however, it is far more expensive and time consuming. The added benefit of the web based survey method is that respondents' answers can be entered into an on-line form when using a web based survey and the answers can be directly downloaded into a database, thereby mitigating many of the typical transcription errors (Schonlau et al., 2001).

In lieu of using the DIT short version, changing the instrumentation to the DIT-2 should be considered for future research. The short version of the DIT was chosen to reduce the possibility of reactive testing effects. Because 36.65% of the completed DIT short version surveys had to be excluded based on scoring protocols, the DIT-2 may be a better choice because it provides information on the selected and purged protocols, which ultimately increases the data available for analysis.

Given the support in the literature for use of the Deliberate Psychological Education (DPE) model for raising levels of moral development, comparing different types of multicultural counseling training for their use of the DPE elements and subsequent moral development growth is also suggested for future consideration.

Finally, including the client perspective in research of multicultural counseling competencies with diverse populations is warranted. According to Fuertes et al. (2001), clients' perceptions are often not considered in multicultural counseling research. The value of considering clients' perspectives is that it provides a collaborative quality to the research in which clients can define not only problems they experience but also include their strengths. In addition, by including clients as partners in services and research, they feel valued.

Summary

The purpose of this study was to investigate the relationships among counselors' moral development, their perceived levels of multicultural counseling knowledge and awareness, and their attitudes toward people with disabilities. A review of the literature indicated that counselors are entering the field with little or no knowledge of disabilities. As this country grows even more pluralistic, the likelihood of counselors working with an individual who has a disability is also growing. The literature regarding multicultural research indicated that counselors with higher functioning levels of multicultural competencies were much more capable of meeting the need of their clients. On the basis of the empirical support regarding the benefits of the moral development model, it was the theoretical framework from which counselors' perceived multicultural competencies and attitudes towards people with disabilities was explored as a way of assisting the counselors in meeting the needs of the growing diversity of clients.

The results indicated that moral development is positively related to multicultural counseling awareness, but not multicultural counseling knowledge. There was no significant relationship found between moral development and attitudes toward people with disabilities. However, a significant positive relationship was found between multicultural counseling awareness and attitudes towards people with disabilities. Awareness was a far stronger variable than multicultural counseling knowledge. This result may indicate that multicultural counseling

knowledge is necessary but not sufficient when considering attitudes towards people with disabilities. The findings may also support the need for cognitive developmentally based counselor education and professional development (i.e., training and supervision). Further implications of this study's findings and suggestions for further research were discussed.

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APPENDICES

Appendix A

Computer Web Based Survey

Introduction e-mail and Follow-up e-mail

e-mail 1:

Dear Counseling Colleague:

I would *truly* appreciate your help with a study for my doctoral dissertation. I'm examining the relationship among counselors' moral reasoning, multicultural awareness and knowledge, and their attitudes towards people who have disabilities. This study has been approved by The College of William and Mary's Human Subjects Committee for Research and will be conducted under the direction of Rick Gressard, Ph.D. (757) 221-2352.

I recognize your time and work within our field is very valuable. This study will also be valuable to the counseling field. It is my hope this research will benefit counselors like you, as you continue to work to provide services to an increasingly diverse population, including the largest minority group – clients who have disabilities. In addition, this research promises to contribute to counseling literature for counselor education programs. This is particularly important for programs to prepare competent counselors who will work effectively with clients who have disabilities. I'll be happy to share a synopsis of the overall results with you if you are interested. Your participation in this research is voluntary, and you may terminate at any time. Your responses, however, are *essential* to future improvements in the field of counseling and counselor training. Therefore, I am asking you to please complete my research survey by **April 30, 2004**. The surveys should take about 25 to 35 minutes to complete and your responses will be held in the strictest confidence.

Again, I know your time is valuable, so all participants who complete the survey will be entered in a drawing for one of three prizes: \$100 gift certificate and two \$50 gift certificates to Barnes and Noble.

When you are ready, you simply need to click on the link listed below, and then type this survey ID number **#CODE#** in the designated area. Then, follow the prompts.

I greatly appreciate your time and the valuable data you will provide through your participation in this research. If you have any questions about this research, please do not hesitate to contact me at (757) 221-2363, (757) 538-0975, or cxsacc@wm.edu. Thank you for your help.

Survey ID number: **#CODE#**
URL LINK HERE

Christine Sacco-Bene, NCC
Doctoral Candidate
The College of William and Mary

e-mail 2:

Dear:

Help! I am appealing to you for your assistance. I am still collecting data and **desperately** need your survey responses. Since the survey is random, each person's data are very important. Without a high enough response rate, I will not have enough to complete my dissertation.

Again, I am asking for you to please complete survey over the Internet by **April 30, 2004**.

The purpose of this study is to examine the relationship between counselors' moral reasoning and perceived multicultural awareness and knowledge to their attitudes towards people who have disabilities. The survey should take only 25 to 35 minutes. Because your time is so valuable, you will be entered in a drawing for one of three prizes (\$100 gift certificate and two \$50 gift certificates to Barnes and Noble) just for completing the survey.

If you have any questions or concerns about this research, please do not hesitate to contact me at (757) 221-2363, (757) 538-0975, or cxsacc@wm.edu.

Please take part in this important research. **Thank you, in advance, for helping me out!**

When you are ready, you simply need to click on the link listed below, and then type this survey ID number **#CODE#** in the designated area. Then, follow the prompts.

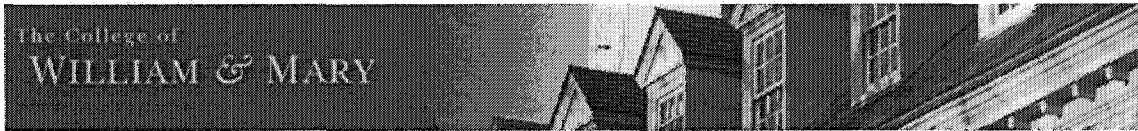
Sincerely,

Christine Sacco-Bene, NCC
Doctoral Candidate
The College of William and Mary

Survey ID number: **#CODE#**
URL LINK HERE

Appendix B

Log-In, Consent Form, Demographic Form,
Survey Questionnaires and Thank you/or Decline
(formatted for internet access)



Survey Login

You will be presented a consent form then a series of surveys. On each survey, answer all questions then click "Submit" to continue to the next survey. All questions must be answered.

To begin, enter the Survey ID in the box below and click "Login".

Survey ID:

Login



Survey Consent

" Relationships between Counselor Development, Multicultural Counseling Competency and Attitudes towards People Who have Disabilities "

I am willing to participate in a study of counselors and understand that the study is being conducted by Christine Sacco-Bene, a doctoral candidate in counselor education at the College of William & Mary. I have read the e-mail cover letter explaining the purpose of the study and understand the following: that participation is voluntary; that due to the computer survey format, I may refuse to answer any question and in so doing will withdraw from the study; and, that I may choose to withdraw at any time during the study.

As a participant in this study, I am aware that this research will take place in a Web survey format and I will be asked to complete five research instruments: the Demographic Survey, the Defining Issues Test - Short Form (DIT), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), the Attitudes Towards Disabled People Scale (ATDP) and the Marlowe-Crowne Social Desirability Scale (MC - Form C). I understand involvement in this study will be approximately 25-35 minutes.

THIS PROJECT WAS FOUND TO COMPLY WITH APPROPRIATE ETHICAL STANDARDS AND WAS EXEMPTED FROM THE NEED FOR FORMAL REVIEW BY THE COLLEGE OF WILLIAM AND MARY PROTECTION OF HUMAN SUBJECTS COMMITTEE (PHONE: 757-221-3901) ON MARCH 22, 2004 AND EXPIRES ON MARCH 22, 2005.

By participating in this study, I understand that there are no obvious risks to my physical or mental health. I also understand that a copy of the results of the study will be e-mailed to me upon request.

- ☐ I am interested in receiving a synopsis of the overall results.
- ☐ I am NOT interested in receiving a synopsis of the overall results.

CONFIDENTIALITY STATEMENT

As a participant in this study, I am aware that all records will be kept confidential and my name will not be associated with any of the results of this study.

- ☐ I fully understand the above statements, and do hereby consent to participate in this study.
- ☐ I choose not to participate in this study.

Submit



Demographic Survey

Age:

Gender:

- ☐ Female
- ☐ Male

Race/Ethnicity:

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ African or African-American/Black
- ☐ Hispanic/Latino(a)
- ☐ Caucasian/European or European-American
- ☐ Multiracial

Highest Educational Level Attained:

- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate
- ☐ Ed.S. (Educational Specialist Degree)
- ☐ ABD (All but dissertation)

Counseling Experience:

- ☐ Practicum only
- ☐ Internship
- ☐ Number of Years Experience:

Degree Focus:

- ☐ Community Counseling
- ☐ School Counseling
- ☐ Mental Health Counseling
- ☐ Family Counseling
- ☐ Substance Abuse Counseling
- ☐ Other:

Where have you received your Multicultural Training?

- ☐ A Multicultural Development class as part of my degree program.
- ☐ Multicultural training was integrated throughout my degree program.
- ☐ A Multicultural Development class as part of degree program and multicultural training was integrated throughout the degree program.
- ☐ Only by attending workshops and trainings outside of a formal degree program.
- ☐ Have not had any multicultural training.
- ☐ Other:

Have you ever taken a specific Disability Studies class in your program of study?

- ☐ Yes
- ☐ No

Do you have a disability?

- ☐ Yes
- ☐ No

Submit



Attitudes Towards Disabled Persons Scale

(Yuker and Block, 1986)

ATDP - O

Instructions:

Below each statement check the appropriate box according to how much you agree or disagree with it. Please mark every one. Check +1, +2, +3 or -1, -2, -3 depending on how you feel in each case.

+3: I AGREE VERY MUCH
+2: I AGREE PRETTY MUCH
+1: I AGREE A LITTLE

-1: I DISAGREE A LITTLE
-2: I DISAGREE PRETTY MUCH
-3: I DISAGREE VERY MUCH

Questions:

1	Parents of children with disabilities should be less strict than other parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
2	Persons with physical disabilities are just as intelligent as non-disabled ones.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
3	People with disabilities are usually easier to get along with than other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
4	Most people with disabilities feel sorry for themselves.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
5	People with disabilities are the same as anyone else.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
6	There should not be special schools for children who have disabilities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
7	It would be best for persons with disabilities to live and work in special communities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
8	It is up to the government to take care of people who have disabilities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
9	Most people with disabilities worry a great deal.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3
10	People with disabilities should not be expected to meet the same standards as non-disabled people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		+3	+2	+1	-1	-2	-3

11 People with disabilities are as happy as people who do not have disabilities.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

12 People with severe disabilities are no harder to get along with than those with minor disabilities.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

13 It is almost impossible for a person who has a disability to lead a normal life.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

14 You should not expect too much from people with disabilities.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

15 People with disabilities tend to keep to themselves much of the time.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

16 People with disabilities are more easily upset than people who do not have disabilities.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

17 Persons with disabilities cannot have a normal social life.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

18 Most people with disabilities feel that they are not as good as other people.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

19 You have to be careful of what you say when you are with people who have disabilities.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

20 People with disabilities are often grouchy.

☐ +3 ☐ +2 ☐ +1 ☐ -1 ☐ -2 ☐ -3

Submit



Opinions About Social Problems

Heinz and the Drug

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Instructions:

This questionnaire is aimed at understanding how people think about social problems. Different people often have different opinions about questions of right and wrong. There are no "right" answers in the way that there are right answers to math problems. You will be asked to give your opinion concerning several problem stories.

For each question, determine its importance to you and check the appropriate circle (GREAT, MUCH, SOME, LITTLE, or NO). For example, after reading a statement and you decide the statement is not at all important, check the 'NO' circle.

Story:

In Europe a woman was near death from a special kind of cancer. There was one drug that the doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost to make. He paid \$200 for the radium and charged \$2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only get together about \$1,000, which is half of what it cost. He told the druggist that his wife was dying, and asked him to sell it cheaper or let him pay later. But the druggist said, "No, I discovered the drug and I'm going to make money from it." So Heinz got desperate and began to think about breaking into the man's store to steal the drug for his wife.

Should Heinz steal the drug? (Check one)

☐ Should steal it

☐ Can't decide

☐ Should not steal it

Questions: Indicate how important each statement is to you.

1 Whether a community's laws are going to be upheld.

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

2 Isn't it only natural for a loving husband to care so much for his wife that he'd steal?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

3 Is Heinz willing to risk getting shot as a burglar or going to jail for the chance that stealing the drug might help?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

4 Whether Heinz is a professional wrestler, or has considerable influence with professional wrestlers.

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

5 Whether Heinz is stealing for himself or doing this solely to help someone else.

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

6 Whether the druggist's rights to his invention have to be respected.

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

7 Whether the essence of living is more encompassing than the termination of dying, socially and individually.

☐ GREAT ☐ MUCH ☐ SOME ☐ LITTLE ☐ NO

8 What values are going to be the basis for governing how people act towards each other.

☐ GREAT ☐ MUCH ☐ SOME ☐ LITTLE ☐ NO

9 Whether the druggist is going to be allowed to hide behind a worthless law which only protects the rich anyhow.

☐ GREAT ☐ MUCH ☐ SOME ☐ LITTLE ☐ NO

10 Whether the law in this case is getting in the way of the most basic claim of any member of society.

☐ GREAT ☐ MUCH ☐ SOME ☐ LITTLE ☐ NO

11 Whether the druggist deserves to be robbed for being so greedy and cruel.

☐ GREAT ☐ MUCH ☐ SOME ☐ LITTLE ☐ NO

12 Would stealing in such a case bring about more total good for the whole society or not.

☐ GREAT ☐ MUCH ☐ SOME ☐ LITTLE ☐ NO

From the list of questions above, select the four most important:

:
First

:
Second

:
Third

:
Fourth

Submit



Opinions About Social Problems

Newspaper

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Instructions:

This questionnaire is aimed at understanding how people think about social problems. Different people often have different opinions about questions of right and wrong. There are no "right" answers in the way that there are right answers to math problems. You will be asked to give your opinion concerning several problem stories.

For each question, determine its importance to you and check the appropriate circle (GREAT, MUCH, SOME, LITTLE, or NO). For example, after reading a statement and you decide the statement is not at all important, check the 'NO' circle.

Story:

Fred, a senior in high school, wanted to publish a mimeographed newspaper for students so that he could express many of his opinions. He wanted to speak out against the use of the military in international disputes and to speak out against some of the school's rules, like the rule forbidding boys to wear long hair.

When Fred started his newspaper, he asked his principal for permission. The principal said it would be all right if before every publication Fred would turn in all his articles for the principal's approval. Fred agreed and turned in several articles for approval. The principal approved all of them and Fred published two issues of the paper in the next two weeks.

But the principal had not expected that Fred's newspaper would receive so much attention. Students were so excited by the paper that they began to organize protests against the hair regulation and other school rules. Angry parents objected to Fred's opinions. They phoned the principal telling him that the newspaper was unpatriotic and should not be published. As a result of the rising excitement, the principal ordered Fred to stop publishing. He gave as a reason that Fred's activities were disruptive to the operation of the school.

Should the principal stop the newspaper? (Check one)

☐ Should stop
 ☐ Can't decide
 ☐ Should not stop it

Questions: Indicate how important each statement is to you.

1 Is the principal more responsible to the students or to the parents?

☐ GREAT
 ☐ MUCH
 ☐ SOME
 ☐ LITTLE
 ☐ NO

2 Did the principal give his word that the newspaper could be published for a long time, or did he just promise to approve the newspaper one issue at a time?

☐ GREAT
 ☐ MUCH
 ☐ SOME
 ☐ LITTLE
 ☐ NO

3 Would the students start protesting even more if the principal stopped the newspaper?

☐ GREAT
 ☐ MUCH
 ☐ SOME
 ☐ LITTLE
 ☐ NO

4 When the welfare of the school is threatened, does the principal have the right to give orders to students?

☐ GREAT
 ☐ MUCH
 ☐ SOME
 ☐ LITTLE
 ☐ NO

5 Does the principal have the freedom of speech to say "no" in this case?

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

6 If the principal stopped the newspaper, would he be preventing full discussion of important problems?

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

7 Whether the principal's order would make Fred lose faith in the principal.

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

8 Whether Fred was really loyal to his school and patriotic to his country.

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

9 What effect would stopping the paper have on the student's education in critical thinking and judgments?

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

10 Whether Fred was in any way violating the rights of others in publishing his own opinions.

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

11 Whether the principal should be influenced by some angry parents when it is the principal who knows best what is going on in the school.

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

12 Whether Fred was using the newspaper to stir up hatred and discontent.

☐
GREAT

☐
MUCH

☐
SOME

☐
LITTLE

☐
NO

From the list of questions above, select the four most important:

First

Second

Third

Fourth

Submit



Opinions About Social Problems

Escaped Prisoner

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Instructions:

This questionnaire is aimed at understanding how people think about social problems. Different people often have different opinions about questions of right and wrong. There are no "right" answers in the way that there are right answers to math problems. You will be asked to give your opinion concerning several problem stories.

For each question, determine its importance to you and check the appropriate circle (GREAT, MUCH, SOME, LITTLE, or NO). For example, after reading a statement and you decide the statement is not at all important, check the 'NO' circle.

Story:

A man had been sentenced to prison for ten years. After one year, however, he escaped from prison, moved to a new area of the country, and took on the name of Thompson. For eight years he worked hard, and gradually he saved enough money to buy his own business. He was fair to his customers, gave his employees top wages, and gave most of his own profits to charity. Then one day Mrs. Jones, an old neighbor, recognized him as the man who had escaped from prison eight years before and for whom the police had been looking.

Should Mrs. Jones report Mr. Thompson to the police and have him sent back to prison? (Check one)

☐ Should report him

☐ Can't decide

☐ Should not report him

Questions: Indicate how important each statement is to you.

1 Hasn't Mr. Thompson been good enough for such a long time to prove he isn't a bad person?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

2 Every time someone escapes punishment for a crime, doesn't that just encourage more crime?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

3 Wouldn't we be better off without prisons and the oppression of our legal system?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

4 Has Mr. Thompson really paid his debt to society?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

5 Would society be failing what Mr. Thompson should fairly expect?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

6 What benefits would prisons be apart from society, especially for a charitable man?

☐ GREAT

☐ MUCH

☐ SOME

☐ LITTLE

☐ NO

7 How could anyone be so cruel and heartless as to send Mr. Thompson to prison?				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GREAT	MUCH	SOME	LITTLE	NO
8 Would it be fair to all the prisoners who had to serve out their full sentences if Mr. Thompson was let off?				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GREAT	MUCH	SOME	LITTLE	NO
9 Was Mrs. Jones a good friend of Mr. Thompson?				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GREAT	MUCH	SOME	LITTLE	NO
10 Wouldn't it be a citizen's duty to report an escaped criminal, regardless of the circumstances?				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GREAT	MUCH	SOME	LITTLE	NO
11 How would the will of the people and the public good best be served.				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GREAT	MUCH	SOME	LITTLE	NO
12 Would going to prison do any good for Mr. Thompson or protect anybody?				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GREAT	MUCH	SOME	LITTLE	NO
From the list of questions above, select the four most important:				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
First	Second	Third	Fourth	

Submit



Marlowe-Crowne Social Desirability Scale

Form C

Instructions:

Check your response either True or False depending on how you feel each item applies to you.

Questions:

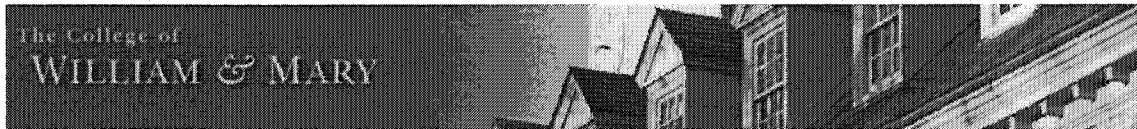
1 It is sometimes hard for me to go on with my work if I am not encouraged.	<input type="radio"/> True	<input type="radio"/> False
2 I sometimes feel resentful when I don't get my way.	<input type="radio"/> True	<input type="radio"/> False
3 On a few occasions, I have given up doing something because I thought too little of my ability.	<input type="radio"/> True	<input type="radio"/> False
4 There have been times when I felt like rebelling against people in authority even though I knew they were right.	<input type="radio"/> True	<input type="radio"/> False
5 No matter who I'm talking to, I'm always a good listener.	<input type="radio"/> True	<input type="radio"/> False
6 There have been occasions when I took advantage of someone.	<input type="radio"/> True	<input type="radio"/> False
7 I'm always willing to admit it when I make a mistake.	<input type="radio"/> True	<input type="radio"/> False
8 I sometimes try to get even rather than forgive and forget.	<input type="radio"/> True	<input type="radio"/> False
9 I am always courteous, even to people who are disagreeable.	<input type="radio"/> True	<input type="radio"/> False
10 I have never been irked when people express ideas very different than my own.	<input type="radio"/> True	<input type="radio"/> False
11 There have been times when I was quite jealous of the good fortune of others.	<input type="radio"/> True	<input type="radio"/> False
12 I am sometimes irritated by people who ask favors of me.	<input type="radio"/> True	<input type="radio"/> False

13 I have never deliberately said something that hurt someone's feelings.

☐
True

☐
False

Submit



Multicultural Counseling Knowledge and Awareness Scale

Multicultural Counseling Knowledge and Awareness Scale (MCKAS)
Copyrighted © by Joseph G. Ponterotto, 1997

A Revision of the Multicultural Counseling Awareness Scale (MCAS)
Copyrighted © by Joseph G. Ponterotto, 1991

Instructions:

Using the following scale, rate the truth of each item as it applies to you.

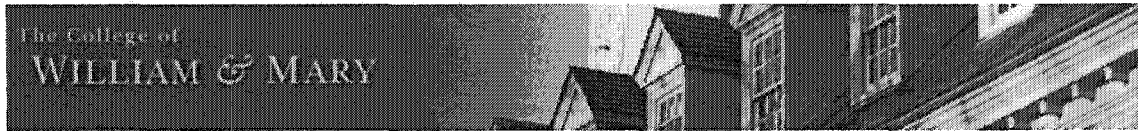
Questions:

1 I believe all clients should maintain direct eye contact during counseling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
2 I check up on my minority/cultural counseling skills by monitoring my functioning - via consultation, supervision, and continuing education.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
3 I am aware some research indicates that minority clients receive "less preferred" forms of counseling treatment than majority clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
4 I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
5 I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
6 I am familiar with the "culturally deficient" and "culturally deprived" depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
7 I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
8 I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
9 I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True
10 I think that clients should perceive the nuclear family as the ideal social unit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at All True		Somewhat True			Totally True

11	I think that being highly competitive and achievement oriented are traits that all clients should work towards.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
12	I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
13	I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
14	I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
15	I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
16	I am knowledgeable of acculturation models for various ethnic minority groups.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
17	I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
18	I believe that it is important to emphasize objective and rational thinking in minority clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
19	I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
20	I believe that my clients should view a patriarchal structure as the ideal.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
21	I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
22	I am comfortable with differences that exist between me and my clients in terms of race and beliefs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
23	I am aware of institutional barriers which may inhibit minorities from using mental health services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
24	I think that my clients should exhibit some degree of psychological mindedness and sophistication.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
25	I believe that minority clients will benefit most from counseling with a majority who endorses White middle-class values and norms.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True
26	I am aware that being born a White person in this society carries with it certain advantages.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Not at All True		Somewhat True			Totally True

- 27 I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients.
- ☐ Not at All True ☐ ☐ Somewhat True ☐ ☐ Totally True
- 28 I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs.
- ☐ Not at All True ☐ ☐ Somewhat True ☐ ☐ Totally True
- 29 I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.
- ☐ Not at All True ☐ ☐ Somewhat True ☐ ☐ Totally True
- 30 I believe that all clients must view themselves as their number one responsibility.
- ☐ Not at All True ☐ ☐ Somewhat True ☐ ☐ Totally True
- 31 I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group.
- ☐ Not at All True ☐ ☐ Somewhat True ☐ ☐ Totally True
- 32 I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions.
- ☐ Not at All True ☐ ☐ Somewhat True ☐ ☐ Totally True

Submit



Thank You

Thank you so much for completing this survey. Your responses are extremely important to future improvements in the counseling field, and I truly appreciate your participation in my research.

Once all data is collected, I'll be drawing the winners of the gift certificates to Barnes and Noble (\$100 and two \$50 prizes). Also, after completing my analysis and dissertation, I'll send you a synopsis of the overall results if you had previously designated interest.

If you have any additional questions, please feel free to contact me at (757) 221-2363, (757) 538-0975, or cxsacc@wm.edu.

Again, thanks for all your help!

Christine Sacco-Bene, NCC
Doctoral Candidate
The College of William and Mary





Declined

Thank you. If you change your mind and choose to participate in this study at a different time, you may login with the same survey ID number.

If you have any additional questions, please feel free to contact me at (757) 221-2363, (757) 538-0975, or cxsacc@wm.edu.

Christine Sacco-Bene, NCC
Doctoral Candidate
The College of William and Mary



Appendix C

Mail Version Survey

Introduction letter, Consent form,

Demographic form, and Survey forms

2736 Burning Tree Lane
Suffolk, VA 23435

DATE

Dear:

I *truly* appreciate your help with my study for my doctoral dissertation. This is essentially the same letter as the first e-mail I sent out, but I wanted to make sure you had all information available to you. I'm examining the relationship among counselors' moral reasoning, multicultural awareness and knowledge, and their attitudes towards people who have disabilities. This study has been approved by The College of William and Mary's Human Subjects Committee for Research and will be conducted under the direction of Rick Gressard, Ph.D. (757) 221-2352.

I recognize your time and work within our field is very valuable. This study will also be valuable to the counseling field. It is my hope this research will benefit counselors like you, as you continue to work to provide services to an increasingly diverse population, including the largest minority group – clients who have disabilities. In addition, this research promises to contribute to counseling literature for counselor education programs. This is particularly important for programs to prepare competent counselors who will work effectively with clients who have disabilities. I'll be happy to share a synopsis of the overall results with you if you are interested. Your participation in this research is voluntary, and you may terminate at any time. Your responses, however, are *essential* to future improvements in the field of counseling and counselor training. Therefore, I am asking you to please complete my research survey and mail it back by May 5, 2004. The surveys should take about 25 to 35 minutes to complete and your responses will be held in the strictest confidence.

Enclosed in this packet is a Demographic Survey, the Defining Issues Test Short Form (DIT), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), the Attitudes Towards Disabled People Scale (ATDP), the Marlowe-Crowne Social Desirability Scale (MC – Form C) and two consent forms.

Please fill out one consent form and return it with the five completed assessments in the enclosed self addressed stamped envelope. The other copy of the consent form is for your records.

Again, I know your time is valuable, so all participants who complete the survey will be entered in a drawing for one of three prizes: \$100 gift certificate and two \$50 gift certificates to Barnes and Noble.

I greatly appreciate your time and the valuable data you will provide through your participation in this research. If you have any questions about this research, please do not hesitate to contact me at (757) 221-2363, (757) 538-0975, or cxsacc@wm.edu. Thank you for your help.

Christine Sacco-Bene, NCC
Doctoral Candidate
The College of William and Mary

enclosures

CONSENT FORM

“Relationships among Counselor Development, Multicultural Counseling Competency, and Attitudes towards People Who have Disabilities”

I am willing to participate in a study of counselors and understand that the study is being conducted by Christine Sacco-Bene, a doctoral candidate in counselor education at the College of William & Mary. I have read the cover letter explaining the purpose of the study and understand the following: that participation is voluntary; that I may refuse to answer any question that is asked; and, that I may choose to withdraw at any time during the study.

As a participant in this study, I am aware that this research will take place in a Web survey format or paper-and-pencil format and I will be asked to complete five research instruments: the Demographic Survey, the Defining Issues Test Short Form (DIT), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), the Attitudes Towards Disabled People Scale (ATDP) and the Marlowe-Crowne Social Desirability Scale (MC – Form C). I understand involvement in this study will be approximately 25-35 minutes.

THIS PROJECT WAS FOUND TO COMPLY WITH APPROPRIATE ETHICAL STANDARDS AND WAS EXEMPTED FROM THE NEED FOR FORMAL REVIEW BY THE COLLEGE OF WILLIAM AND MARY PROTECTION OF HUMAN SUBJECTS COMMITTEE (PHONE: 757-221-3901) ON MARCH 22, 2004 AND EXPIRES ON MARCH 22, 2005.

By participating in this study, I understand that there are no obvious risks to my physical or mental health. I also understand that a copy of the results of the study will be e-mailed to me upon request.

- ☐ I *am* interested in receiving a synopsis of the overall results.
☐ I *am not* interested in receiving a synopsis of the overall results.

CONFIDENTIALITY STATEMENT

As a participant in this study, I am aware that all records will be kept confidential and my name will not be associated with any of the results of this study.

I fully understand the above statements, and do hereby consent to participate in this study.

Date

Participant's Signature

Please print your name

DEMOGRAPHIC SURVEY

Age: _____

Gender: ☐ Female ☐ Male

Race/Ethnicity:

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ African or African-American/Black
- ☐ Hispanic/Latino(a)
- ☐ Caucasian/European or European-American
- ☐ Multiracial

Highest Educational Level Attained:

- ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate
- ☐ Ed.S. (Educational Specialist Degree) ☐ ABD (All but dissertation)

Counseling Experience:

- ☐ Practicum only ☐ Internship ☐ number of years experience _____

Degree Focus:

- ☐ Community Counseling ☐ School Counseling
- ☐ Mental Health Counseling ☐ Substance Abuse Counseling
- ☐ Other _____

Where have you received your Multicultural Training?

- ☐ A Multicultural Development class as part of my degree program.
- ☐ Multicultural training was integrated throughout my degree program.
- ☐ Only by attending workshops and trainings outside of a formal degree program.
- ☐ Have not had any multicultural training.
- ☐ Other _____

Have you ever taken a specific Disability Studies class in your program of study?

- ☐ Yes ☐ No

Do you have a disability?

- ☐ Yes ☐ No

Thank you... Please continue by filling out the following surveys.

Defining Issues Test (DIT)

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OPINIONS ABOUT SOCIAL PROBLEMS

This questionnaire is aimed at understanding how people think about social problems. Different people often have different opinions about questions of right and wrong. There are no "right" answers in the way that there are right answers to math problems. You will be asked to give your opinion concerning several problem stories. Here is a story as an example:

Frank Jones has been thinking about buying a car. He is married, has two small children and earns an average income. The car he buys will be his family's only car. It will be used mostly to get to work and drive around town, but sometimes for vacations trips also. In trying to decide what car to buy, Frank Jones realized that there were a lot of questions to consider. Below there is a list of some of these questions.

If you were Frank Jones, how important would each of these questions be in deciding what car to buy?

Instructions for Part A: (Sample Question)

On the left-hand side of the page, check one of the spaces by each question to indicate its importance

Importance					
Great	Much	Some	Little	No	
___	___	___	___	<u>✓</u>	1. Whether the car dealer was in the same block as where Frank lives? (Note that the person did not think this was important in making a decision.)
<u>✓</u>	___	___	___	___	2. Would a used car be more economical in the long run than a new car? (Note that a check was put in the far left space to indicate that it is an important issue in making a decision about buying a car.)
___	___	<u>✓</u>	___	___	3. Whether the color was green, Frank's favorite color
___	___	___	___	<u>✓</u>	4. Whether the cubic inch displacement was at least 200. (Note that if you are unsure about what "cubic inch displacement" means, then mark it "no importance.")
<u>✓</u>	___	___	___	___	5. Would a large, roomy car be better than a compact car?
___	___	___	___	<u>✓</u>	6. Whether the front connibilles were differential. (Note that if a statement sounds like gibberish or nonsense to you, mark it "no importance.")

Part B: (Sample Question)

From the list of questions and considerations above, select the most important one of the whole group. Put the number of the most important question on the top line below. Do likewise for your 2nd, 3rd, and 4th most important choices.

- 5 Most important
- 2 Second most important
- 3 Third most important
- 1 Fourth most important

NEWSPAPER

Fred, a senior in high school, wanted to publish a mimeographed newspaper for students so that he could express many of his opinions. He wanted to speak out against the use of the military in international disputes and to speak out against some of the school's rules, like the rule forbidding boys to wear long hair.

When Fred started his newspaper, he asked his principal for permission. The principal said it would be all right if before every publication Fred would turn in all his articles for the principal's approval. Fred agreed and turned in several articles for approval. The principal approved all of them and Fred published two issues of the paper in the next two weeks.

But the principal had not expected that Fred's newspaper would receive so much attention. Students were so excited by the paper that they began to organize protests against the hair regulation and other school rules. Angry parents objected to Fred's opinions. They phoned the principal telling him that the newspaper was unpatriotic and should not be published. As a result of the rising excitement, the principal ordered Fred to stop publishing. He gave as a reason that Fred's activities were disruptive to the operation of the school.

Should the principal stop the newspaper? (Check One)

_____ Should stop it

_____ Can't decide

_____ Should not stop it

NEWSPAPER

GREAT **MUCH** **SOME** **LITTLE** **NO**
importance importance importance importance importance

On the left-hand side of the page check one of the spaces by each question to indicate its importance.

_____	_____	_____	_____	_____	1. Is the principal more responsible to the students or to the parents?
_____	_____	_____	_____	_____	2. Did the principal give his word that the newspaper could be published for a long time, or did he just promise to approve the newspaper one issue at a time?
_____	_____	_____	_____	_____	3. Would the students start protesting even more if the principal stopped the newspaper?
_____	_____	_____	_____	_____	4. When the welfare of the school is threatened, does the principal have the right to give orders to students?
_____	_____	_____	_____	_____	5. Does the principal have the freedom of speech to say "no" in this case?
_____	_____	_____	_____	_____	6. If the principal stopped the newspaper, would he be preventing full discussion of important problems?
_____	_____	_____	_____	_____	7. Whether the principal's order would make Fred lose faith in the principal.
_____	_____	_____	_____	_____	8. Whether Fred was really loyal to his school and patriotic to his country.
_____	_____	_____	_____	_____	9. What effect would stopping the paper have on the student's education in critical thinking and judgments?
_____	_____	_____	_____	_____	10. Whether Fred was in any way violating the rights of others in publishing his own opinions.
_____	_____	_____	_____	_____	11. Whether the principal should be influenced by some angry parents when it is the principal who knows best what is going on in the school.
_____	_____	_____	_____	_____	12. Whether Fred was using the newspaper to stir up hatred and discontent.

From the list of questions above, select the four most important:

Most important _____

Second most important _____

Third most important _____

Fourth most important _____

ESCAPED PRISONER

A man had been sentenced to prison for ten years. After one year, however, he escaped from prison, moved to a new area of the country, and took on the name of Thompson. For eight years he worked hard, and gradually he saved enough money to buy his own business. He was fair to his customers, gave his employees top wages, and gave most of his own profits to charity. Then one day Mrs. Jones, an old neighbor, recognized him as the man who had escaped from prison eight years before and for whom the police had been looking.

Should Mrs. Jones report Mr. Thompson to the police and have him sent back to prison? (Check one)

- ☐ Should report him
- ☐ Can't decide
- ☐ Should not report him

ESCAPED PRISONER

GREAT importance	MUCH importance	SOME importance	LITTLE importance	NO importance	
_____	_____	_____	_____	_____	1. Hasn't Mr. Thompson been good enough for such a long time to prove he isn't a bad person?
_____	_____	_____	_____	_____	2. Every time someone escapes punishment for a crime, doesn't that just encourage more crime?
_____	_____	_____	_____	_____	3. Wouldn't we be better off without prisons and the oppression of our legal system?
_____	_____	_____	_____	_____	4. Has Mr. Thompson really paid his debt to society?
_____	_____	_____	_____	_____	5. Would society be failing what Mr. Thompson should fairly expect?
_____	_____	_____	_____	_____	6. What benefits would prisons be apart from society, especially for a charitable man?
_____	_____	_____	_____	_____	7. How could anyone be so cruel and heartless as to send Mr. Thompson to prison?
_____	_____	_____	_____	_____	8. Would it be fair to all the prisoners who had to serve out their full sentences if Mr. Thompson was let off?
_____	_____	_____	_____	_____	9. Was Mrs. Jones a good friend of Mr. Thompson?
_____	_____	_____	_____	_____	10. Wouldn't it be a citizen's duty to report an escaped criminal, regardless of the circumstances?
_____	_____	_____	_____	_____	11. How would the will of the people and the public good best be served.
_____	_____	_____	_____	_____	12. Would going to prison do any good for Mr. Thompson or protect anybody?

From the list of questions above, select the four most important:

Most important _____

Second most important _____

Third most important _____

Fourth most important _____

HEINZ AND THE DRUG

In Europe a woman was near death from a special kind of cancer. There was one drug that the doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost to make. He paid \$200 for the radium and charged \$2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only get together about \$ 1,000, which is half of what it cost. He told the druggist that his wife was dying, and asked him to sell it cheaper or let him pay later. But the druggist said, "No, I discovered the drug and I'm going to make money from it." So Heinz got desperate and began to think about breaking into the man's store to steal the drug for his wife.

Should Heinz steal the drug? (Check one)

- ☐ Should steal it
- ☐ Can't decide
- ☐ Should not steal it

HEINZ STORY

GREAT importance	MUCH importance	SOME importance	LITTLE importance	NO importance	
_____	_____	_____	_____	_____	1. Whether a community's laws are going to be upheld.
_____	_____	_____	_____	_____	2. Isn't it only natural for a loving husband to care so much for his wife that he'd steal?
_____	_____	_____	_____	_____	3. Is Heinz willing to risk getting shot as a burglar or going to jail for the chance that stealing the drug might help?
_____	_____	_____	_____	_____	4. Whether Heinz is a professional wrestler, or has considerable influence with professional wrestlers.
_____	_____	_____	_____	_____	5. Whether Heinz is stealing for himself or doing this solely to help someone else.
_____	_____	_____	_____	_____	6. Whether the druggist's rights to his invention have to be respected.
_____	_____	_____	_____	_____	7. Whether the essence of living is more encompassing than the termination of dying, socially and individually.
_____	_____	_____	_____	_____	8. What values are going to be the basis for governing how people act towards each other.
_____	_____	_____	_____	_____	9. Whether the druggist is going to be allowed to hide behind a worthless law which only protects the rich anyhow.
_____	_____	_____	_____	_____	10. Whether the law in this case is getting in the way of the most basic claim of any member of society.
_____	_____	_____	_____	_____	11. Whether the druggist deserves to be robbed for being so greedy and cruel.
_____	_____	_____	_____	_____	12. Would stealing in such a case bring about more total good for the whole society or not.

From the list of questions above, select the four most important:

Most important	_____
Second most important	_____
Third most important	_____
Fourth most important	_____

ATTITUDES TOWARDS DISABLED PERSONS SCALE
 (Yuker and Block, 1986)
ATDP – O

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3 or -1, -2, -3; depending on how you feel in each case.

+3: I AGREE VERY MUCH	-1: I DISAGREE A LITTLE
+2: I AGREE PRETTY MUCH	-2: I DISAGREE PRETTY MUCH
+1: I AGREE A LITTLE	-3: I DISAGREE VERY MUCH

- | | | |
|-------|-----|---|
| _____ | 1. | Parents of children with disabilities should be less strict than other parents. |
| _____ | 2. | Persons with physical disabilities are just as intelligent as non-disabled ones. |
| _____ | 3. | People with disabilities are usually easier to get along with than other people. |
| _____ | 4. | Most people with disabilities feel sorry for themselves. |
| _____ | 5. | People with disabilities are the same as anyone else. |
| _____ | 6. | There should not be special schools for children who have disabilities. |
| _____ | 7. | It would be best for persons with disabilities to live and work in special communities. |
| _____ | 8. | It is up to the government to take care of people who have disabilities. |
| _____ | 9. | Most people with disabilities worry a great deal. |
| _____ | 10. | People with disabilities should not be expected to meet the same standards as non-disabled people. |
| _____ | 11. | People with disabilities are as happy as people who do not have disabilities. |
| _____ | 12. | People with severe disabilities are no harder to get along with than those with minor disabilities. |
| _____ | 13. | It is almost impossible for a person who has a disability to lead a normal life. |

- _____ 14. You should not expect too much from people with disabilities.
- _____ 15. People with disabilities tend to keep to themselves much of the time.
- _____ 16. People with disabilities are more easily upset than people who do not have disabilities.
- _____ 17. Persons with disabilities cannot have a normal social life.
- _____ 18. Most people with disabilities feel that they are not as good as other people.
- _____ 19. You have to be careful of what you say when you are with people who have disabilities.
- _____ 20. People with disabilities are often grouchy.

Multicultural Counseling Knowledge and Awareness Scale (MCKAS)

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A Revision of the Multicultural Counseling Awareness Scale (MCKAS)

Copyrighted © by Joseph G. Ponterotto, 1991

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at			Somewhat			Totally
All True			True			True

1. I believe all clients should maintain direct eye contact during counseling.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

2. I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

3. I am aware some research indicates that minority clients receive “less preferred” forms of counseling treatment than majority clients.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

6. I am familiar with the “culturally deficient” and “culturally deprived” depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

10. I think that clients should perceive the nuclear family as the ideal social unit.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

11. I think that being highly competitive and achievement oriented are traits that all clients should work towards.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

12. I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

16. I am knowledgeable of acculturation models for various ethnic minority groups.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

17. I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

18. I believe that it is important to emphasize objective and rational thinking in minority clients.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

20. I believe that my clients should view a patriarchal structure as the ideal.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

23. I am aware of institutional barriers which may inhibit minorities from using mental health services.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

24. I think that my clients should exhibit some degree of psychological mindedness and sophistication.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

25. I believe that minority clients will benefit most from counseling with a majority who endorses White middle-class values and norms.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

26. I am aware that being born a White person in this society carries with it certain advantages.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

30. I believe that all clients must view themselves as their number one responsibility.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Thank you for completing this instrument. Please feel free to express in writing below any thoughts, concerns, or comments you have regarding this instrument:

MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

Form C

Circle your response either True or False depending on how you feel each item applies to you.

- | | | |
|---|------|-------|
| 1. It is sometimes hard for me to go on with my work if I am not encouraged. | True | False |
| 2. I sometimes feel resentful when I don't get my way. | True | False |
| 3. On a few occasions, I have given up doing something because I thought too little of my ability. | True | False |
| 4. There have been times when I felt like rebelling against people in authority even though I knew they were right. | True | False |
| 5. No matter who I'm talking to, I'm always a good listener. | True | False |
| 6. There have been occasions when I took advantage of someone. | True | False |
| 7. I'm always willing to admit it when I make a mistake. | True | False |
| 8. I sometimes try to get even rather than forgive and forget. | True | False |
| 9. I am always courteous, even to people who are disagreeable. | True | False |
| 10. I have never been irked when people express ideas very different than my own. | True | False |
| 11. There have been times when I was quite jealous of the good fortune of others. | True | False |
| 12. I am sometimes irritated by people who ask favors of me. | True | False |
| 13. I have never deliberately said something that hurt someone's feelings. | True | False |

Appendix D

Frequency Tables

DIT, MCKAS, ATDP-O, and

Marlowe-Crowne Social Desirability Scale

Table D.1
Participants' DIT Scores

DIT P-Score	Frequency	Percentage
6.67	1	0.83%
10	5	4.13%
13.33	1	0.83%
16.67	3	2.48%
20	4	3.31%
23.33	5	4.13%
26.67	5	4.13%
30	10	8.26%
33.33	10	8.26%
36.67	9	7.44%
40	6	4.96%
43.33	5	4.13%
46.67	7	5.79%
50	5	4.13%
53.33	7	5.79%
56.67	10	8.26%
60	10	8.26%
63.33	2	1.65%
66.67	5	4.13%
70	4	3.31%
73.33	2	1.65%
76.67	1	0.83%
80	3	2.48%
83.33	1	0.83%
Total	121	100%

Note. N = 121, seventy (70) of the DIT protocols failed to pass one or more of the four reliability checks of the DIT.

Table D.2
Participants' MCKAS Knowledge Scale Scores (N = 121)

Knowledge Scale	Frequency	Percentage
42	1	.83%
62	1	.83%
63	1	.83%
70	1	.83%
75	1	.83%
77	1	.83%
78	1	.83%
79	2	1.65%
80	2	1.65%
82	2	1.65%
83	2	1.65%
84	1	.83%
85	1	.83%
86	1	.83%
88	3	2.48%
91	1	.83%
92	3	2.48%
93	4	3.31%
94	2	1.65%
95	2	1.65%
96	3	2.48%
97	3	2.48%
98	3	2.48%
99	2	1.65%
100	3	2.48%
101	1	.83%
102	4	3.31%
103	3	2.48%
104	5	4.13%
105	3	2.48%
106	3	2.48%
107	1	.83%
108	1	.83%

109	3	2.48%
110	2	1.65%
111	4	3.31%
112	3	2.48%
113	1	.83%
114	2	1.65%
115	5	4.13%
116	4	3.31%
117	2	1.65%
118	1	.83%
119	6	4.96%
120	5	4.13%
121	1	.83%
124	2	1.65%
125	3	2.48%
127	1	.83%
128	1	.83%
130	2	1.65%
131	1	.83%
135	1	.83%
137	1	.83%
138	1	.83%
140	1	.83%
Total	121	100%

Note. N = 121

Table D.3
Participants' MCKAS Knowledge Scale Scores (N = 191)

Knowledge Scale	Frequency	Percentage
42	1	.52%
62	1	.52%
63	1	.52%
70	1	.52%
75	1	.52%
77	2	1.05%
78	3	1.57%
79	2	1.05%
80	2	1.05%
81	1	.52%
82	2	1.05%
83	4	2.09%
84	3	1.57%
85	1	.52%
86	3	1.57%
87	1	.52%
88	3	1.57%
90	2	1.05%
91	1	.52%
92	4	2.09%
93	5	2.62%
94	3	1.57%
95	5	2.62%
96	6	3.14%
97	6	3.14%
98	3	1.57%
99	6	3.14%
100	3	1.57%
101	1	.52%
102	6	3.14%
103	3	1.57%
104	8	4.19%
105	3	1.57%

106	4	2.09%
107	3	1.57%
108	3	1.57%
109	5	2.62%
110	3	1.57%
111	5	2.62%
112	6	3.14%
113	3	1.57%
114	4	2.09%
115	7	3.66%
116	6	3.14%
117	2	1.05%
118	1	.52%
119	7	3.66%
120	6	3.14%
121	2	1.05%
122	3	1.57%
124	2	1.05%
125	5	2.62%
127	1	.52%
128	2	1.05%
129	2	1.05%
130	2	1.05%
131	1	.52%
134	2	1.05%
135	1	.52%
136	2	1.05%
137	2	1.05%
138	1	.52%
140	1	.52%
Total	191	100%

Note. N = 191

Table D.4
Participants' MCKAS Awareness Scale Scores (N = 121)

Score	Frequency	Percentage
47	1	.83%
48	1	.83%
49	1	.83%
55	1	.83%
56	1	.83%
57	1	.83%
59	1	.83%
60	5	4.13%
61	7	5.79%
62	2	1.65%
63	2	1.65%
64	5	4.13%
65	5	4.13%
66	5	4.13%
67	9	7.44%
68	2	1.65%
69	2	1.65%
70	1	.83%
71	7	5.79%
72	5	4.13%
73	5	4.13%
74	3	2.48%
75	6	4.96%
76	8	6.61%
77	9	7.44%
78	2	1.65%
79	4	3.31%
80	6	4.96%
81	3	2.48%
82	5	4.13%
83	5	4.13%
84	1	.83%
Total	121	100%

Note. N = 121

Table D.5
Participants' MCKAS Awareness Scale Scores (N = 191)

Score	Frequency	Percentage
40	1	.52%
47	1	.52%
48	1	.52%
49	1	.52%
52	1	.52%
55	3	1.57%
56	1	.52%
57	2	1.05%
59	2	1.05%
60	8	4.19%
61	8	4.19%
62	5	2.62%
63	5	2.62%
64	6	3.14%
65	5	2.62%
66	9	4.71%
67	12	6.28%
68	6	3.14%
69	7	3.66%
70	1	.52%
71	10	5.24%
72	6	3.14%
73	8	4.19%
74	8	4.19%
75	9	4.71%
76	11	5.76%
77	12	6.28%
78	7	3.66%
79	7	3.66%
80	9	4.71%
81	4	2.09%
82	7	3.66%
83	7	3.66%
84	1	.52%
Total	191	100%

Note. N = 191

Table D.6
Participants' ATDP Scale Scores (N = 121)

Score	Frequency	Percentage
61	1	.83%
62	1	.83%
64	2	1.65%
65	1	.83%
66	1	.83%
67	2	1.65%
69	1	.83%
70	1	.83%
71	2	1.65%
72	1	.83%
73	2	1.65%
74	4	3.31%
76	1	.83%
77	2	1.65%
78	1	.83%
79	1	.83%
80	4	3.31%
81	3	2.48%
82	4	3.31%
83	2	1.65%
84	4	3.31%
85	7	5.79%
86	2	1.65%
87	7	5.79%
88	2	1.65%
89	1	.83%
90	6	4.96%
91	3	2.48%
92	3	2.48%
93	2	1.65%
94	4	3.31%
95	3	2.48%
96	4	3.31%
97	6	4.96%
98	4	3.31%
99	2	1.65%
100	5	4.13%
101	3	2.48%
102	5	4.13%
103	1	.83%
104	2	1.65%
106	1	.83%
107	1	.83%
109	1	.83%
110	1	.83%
112	1	.83%
113	1	.83%
115	1	.83%
120	1	.83%
Total	121	100%

Table D.7
 Participants' ATDP Scale Scores (N = 191)

Score	Frequency	Percentage
50	1	.52%
57	1	.52%
58	1	.52%
61	2	1.05%
62	2	1.05%
63	1	.52%
64	2	1.05%
65	1	.52%
66	2	1.05%
67	2	1.05%
69	3	1.57%
70	2	1.05%
71	2	1.05%
72	3	1.57%
73	2	1.05%
74	4	2.09%
75	1	.52%
76	2	1.05%
77	5	2.62%
78	1	.52%
79	5	2.62%
80	7	3.66%
81	4	2.09%
82	5	2.62%
83	3	1.57%
84	6	3.14%
85	7	3.66%
86	6	3.14%
87	11	5.76%
88	4	2.09%
89	3	1.57%
90	6	3.14%
91	6	3.14%
92	5	2.62%
93	4	2.09%
94	7	3.66%
95	4	2.09%
96	6	3.14%
97	8	4.19%
98	4	2.09%
99	2	1.05%
100	9	4.71%
101	4	2.09%
102	6	3.14%
103	1	.52%
104	4	2.09%
106	2	1.05%
107	2	1.05%
108	1	.52%
109	1	.52%

110	3	1.57%
112	1	.52%
113	2	1.05%
115	1	.52%
120	1	.52%
Total	191	100%

Note. N = 191

Table D.8

Participants' Marlowe-Crowne Social Desirability Scale Scores (N = 121)

Score	Frequency	Percentage
0	6	4.96%
1	5	4.13%
2	13	10.74%
3	15	12.40%
4	11	9.10%
5	8	6.61%
6	12	9.92%
7	13	10.74%
8	15	12.40%
9	6	4.96%
10	8	6.61%
11	4	3.31%
12	4	3.31%
13	1	.83%
Total	121	100%

Note. N = 121.

Table D.9

Participants' Marlowe-Crowne Social Desirability Scale Scores (N = 191)

Score	Frequency	Percentage
0	10	5.24%
1	9	4.71%
2	18	9.42%
3	22	11.52%
4	17	8.90%
5	11	5.76%
6	24	12.57%
7	22	11.52%
8	23	12.04%
9	10	5.24%
10	10	5.24%
11	8	4.19%
12	6	3.14%
13	1	.52%
Total	191	100%

Note. N = 191.